PROFESSIONAL DISCLOSURE STATEMENT
Covenant Counseling

212 W. Wackerly Rd. Suite 200 • Midland, MI 48640
Phone: (989) 835-8344 FAX: (989) 837-8655 • Web: CovenantCounseling.net

Thank you for the honor to serve you. The Michigan Public Health Code requires that a licensed counselor furnish a professional disclosure statement to all prospective clients before engaging in counseling services. We also want you to be well informed regarding your prospective counselor's credentials and level of experience before your first consultation. Please read the following information and sign indicating that you have read and understood the statement. You will also be furnished with a copy to keep.

Terry Lodico, M.A., M. Div., NCC, LPC

Mr. Lodico provides individual, marital, family and group counseling. He received a B.A. degree from Ashland University, Ashland, OH in 1974, and a Master of Divinity degree in 1978 and an M.A. in Pastoral Psychology and Counseling in 1980 from Ashland Theological Seminary. His counseling experience includes 30 years of counseling through church ministry as well as professionally. He receives yearly education and training to fulfill requirements as a National Certified Counselor and an International Certified Christian Counselor. Terry is licensed by the State of Michigan. The licensing bureau's address and phone number is:

Department of Community Health
Complaint and Allegation Division
P.O. Box 30670 • Lansing, MI 48909
(517) 373-9196

What to Expect:

First Session: The first session is called the diagnostic session. In this session the primary goal is to identify and evaluate the problems. If time allows, your therapist will begin to work with you to define a treatment plan outlining goals, objectives, approaches or interventions to address the reason for your coming to therapy. You are expected to play a major role in determining the treatment plan.

Continuing Sessions: Your therapist will listen, guide in processing and exploring feelings, facilitate solving of issues, structure exercises, offer suggestions, facilitate the practice and development of skills, gently challenge and explore alternative options, and give homework exercises.

Informed Consent of Therapy

We want you to be confident and informed of our therapy approach.

New research, techniques and knowledge in the psychological field continue to expand to improve therapy. As a result, it has been found that certain skills and therapy approaches are more effective with certain counseling needs than others. Because of this, we are eclectic in our approach using differing therapy skills. A main approach is Cognitive Behavioral Therapy (CBT). Research finds this model effective with most needs and it is compatible to a Christian or biblical worldview. The approach recognizes that right thinking and behavior can help one's mood, feelings and attitudes (Rom. 12:2, Eph. 4:23). At the same time, we use certain psychodynamic skills to bring subconscious emotional memories to a conscious level to allow cognitive reframing; we use Gestalt techniques to bring about awareness of what is presently happening in the client's life to gain clarity and insight. Other approaches we may use are as follows:

Interpersonal Therapy (IPT)
Interpersonal Skill Training
Process and Supportive Counseling
Marriage Communication Skills
Emotional/Behavioral Management Skills
Rational Emotive Therapy (RET)
Family System or Family Therapy
Dialectical Therapy
Educational or Insight-Oriented Therapy
In-vivo Exposure for Obsessive Compulsive Disorder
Twelve Steps for Addiction and Dysfunctional Backgrounds
Trauma Focus or Supportive Therapy for Post Traumatic Stress
Spiritual Formation
Biblical Integration
Art and Play Therapy for Children
Group Therapy
Medication Referral
Love Interventions for Substance Abuse and Conduct Disorders
Inventory Testing
Grief and Trauma Processing

FEES:

The counseling fee is $98.00 per fifty-minute session or $94 if payment by cash or check is received at the time of the appointment. Extended sessions may be requested. The initial diagnostic interview is $130, which includes 50 minutes with the client and additional time for evaluation and planning of the treatment. There may be other costs for requested reports or psychological testing. Telephone calls of more than four minutes are considered consultations and pro-rated at the fee rate. We are happy to assist you with any insurance coverage or employment assistance coverage requirements**.** If you anticipate financial difficulty, discuss your circumstances immediately with your counselor for options. A sliding scale is available based on income and the number of dependents in the household. **Payments are due at the closing of each session.** A 1.5% finance charge per month will be added to all accounts over 30 days past due except for payment plan arrangements made between Covenant Counseling and the client.

Cancellation and Missed Appointments

An ethical issue that client and therapist must address from time to time is appointments that are canceled, forgotten or not kept. Occasionally a therapist may lose an hour, two hours or three hours in a day of counseling time when this happens. Other clients lose the opportunity to take these time slots and it costs the office financially. We understand that clients have to cancel because of sickness or emergency situations and we all, now and then, forget or misread our schedules. With this in mind, the following is our policy to mutually work together:

If you cancel within 24 hours of your appointment or on a Saturday or Sunday for a Monday appointment, you are responsible for the session fee. If the appointment was missed due to sickness, a family hardship or something legitimate outside your control, you will be responsible for $50 of the regular $98 charge. You can notify your counselor by simply calling the office and leaving a message.

We ask that when you are ready to terminate therapy you communicate this with your counselor. Do not terminate by not showing for an appointment. Thank you for your cooperation in helping us be efficient for our clients.

JUDICIAL REQUESTS: Occasionally a therapist is requested to appear in court on behalf of a client. If you request or your therapist is subpoenaed to appear in court on your behalf, you agree to pay the hourly rate of $110 for your therapist's preparation, travel and appearance time.

By signing below, I acknowledge I have read and understand this disclosure statement. I understand that my counselor will discuss treatment goals as part of the therapy process. If needed, I agree to talk with my counselor to clarify any of the above approaches of treatment.

I have read and understood this Disclosure Statement and the Informed Consent of Therapy:

_____ _____

Signature of Patient or Personal Representative and Your Relationship to the Patient Date

_____ _____

Signature of Patient or Personal Representative and Your Relationship to the Patient Date

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On a separate form is the **"Confidentiality and Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations."** Please sign below that you have read this form and filled out the information indicating how you would like to be contacted, giving us the right to remind you of appointments:

_____ _____

Signature of Patient or Personal Representative and Your Relationship to the Patient Date

_____ _____

Signature of Patient or Personal Representative and Your Relationship to the Patient Date

EMERGENCIES

In case of an immediate emergency when your therapist cannot be reached, call the Crisis Intervention Service (989) 631-4450 or dial 911.

Covenant Counseling
212 West Wackerly, Suite 200
Midland, MI 48640

Date: _____

Initial Data Form

Please fill in the following information:
Patient Name: _____
Address _____ City: _____
State: _____ Zip: _____
DOB*: ____/___/_____ Social Security #: _____
Day Phone: _____ Home Phone: _____

Highest Educational Degree _____ Occupation: _____
Place of Work or Company Name: _____

Spouse or Parent Names: _____
Address _____ City: _____
State: _____ Zip: _____
DOB*: ____/___/_____ Social Security #: _____
Day Phone: _____ Home Phone: _____

Highest Educational Degree _____ Occupation: _____
Place of Work or Company Name: _____

Purpose seeking counseling: _____
_____
_____
Issues and goals you would like to address: _____
_____
_____

Who referred you to Covenant Counseling? _____
Other counselors you or your family member has seen (Include the year and any diagnosis):
_____
_____
Indicate physical issues, past and present: _____
_____
_____
List stresses: _____
_____
List patient medications: _____
_____
Religious affiliation if any: _____

Circle to indicate the level of your spiritual interest:	1	2	3	4	5
Spouses spiritual interest:	1	2	3	4	5
	Low Interest				High Interest

Do you use **alcohol**? Yes No Do you use uncontrolled substances? Yes No
Has either of these ever been a problem in your life? _____

Does the spouse use alcohol? Yes No Does the spouse use uncontrolled substances? Yes No
Has either of these ever been a problem in your life? _____

See Back

If applicable:
Present status (Circle One): single, married, separated or divorced
Your Present Marriage is you're: 1st, 2nd, 3rd, ____
Your Spouse's Present Marriage is the: 1st, 2nd, 3rd, ____

Your Children:

Name	DOB*	BAP♦ Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.

Spouse's Children:

Name	DOB*	BAP Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.

Primary Insurance: _____
Billing Address: _____
_____
Secondary Insurance: _____
Billing Address: _____
_____

I understand that if my insurance fails to pay Covenant Counseling for any reason I am responsible for full payment of my account.

Signed: _____Date: _____

Signed: _____Date: _____

* Date of Birth
* Date of Birth
♦**Biological or Adopting Parent**: Identify biological spouse by indicating the spouse is of which marriage using **1st, 2nd, 3rd**, etc., **P** = present, or **BSP** = Born of single parent.

Confidentiality and Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations

Patient Name _____

Organization Granted this Consent: ***Covenant Counseling, 212 W. Wackerly, Suite 200, Midland, MI 48640***

Confidentiality:

We want you to know that we regard confidentiality an important component of effective therapy and privileged communication a right of all clients according to the law. Exceptions to this confidentiality are as follows:

- If the client requests that we bill their insurance company or a third party, diagnosis and dates of service are shared to collect payments when required.
- When the client signs a release of information.
- Mandated reporting of physical or sexual abuse of children, threats of suicide or homicide and those required by law. As a mental health practitioner, I will under no circumstances inform such individuals without first sharing that intention with the client, unless it is not possible to do so. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.
- Information necessary for supervision or consultation of therapy.
- Information handled as outlined in the HIPAA Notice of Privacy Practice.

Records: Records are kept concerning your therapy. If you prefer your therapist keep no records, you must give a written request to this effect for your file. If this is done, the only record kept will be the date of your attendance. Without a record, requests from third party payers such as insurance companies cannot be made.

Couple Counseling Policy:
If you and your partner decide to have some individual sessions along with your joint therapy sessions, what you say in individual sessions is considered to be part of the couple's therapy and the information maybe discussed in joint sessions.

HIPAA Regulations:

In our effort to keep privileged information confidential and at the same time provide treatment, federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our **Notice of Privacy Practices.** You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

Phone Contact:

We, at times, phone to remind our clients of their appointment or to be in contact for various reasons. **Please indicate below the ways you would like to be contacted by writing your initials in the corresponding boxes:**

Home	
Work	
Cell phone	

Give us any contact instructions: _____.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

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Counseling Problem Checklist

Name: _____

Age: _____ Date filled out: _____

Check any of the following problems that you experience:

√		√	
	Depression		Feeling that you are not real
	Low energy		Feeling that things around you are not real
	Low self-esteem		Lose track of time
	Poor concentration		Unpleasant thoughts won't go away
	Hopelessness		Anger management/frustration
	Worthlessness		Easily agitated/annoyed
	Guilt		Difficulty with rules/submitting to authority
	Sleep disturbance (more/less)		Habit blaming others
	Appetite disturbance (more/less)		Tend to argue & be defensive
	Thoughts of hurting yourself		Excessive use of drugs and/or alcohol
	Thoughts of hurting someone		Excessive use of prescription medications
	Isolation/social withdrawal		Blackouts
	Sadness/loss		Physical abuse issues
	Stress		Sexual abuse issues
	Anxiety/panic		Spousal abuse issues
	Heart pounding/racing		Loneliness
	Chest pain		Nightmares
	Trembling/shaking		Intrusive thoughts
	Sweating		Headaches
	Chills/hot flashes		Sexual problems
	Tingling/numbness		Suicidal thoughts
	Fear of dying		Relationship problems
	Nausea/Stomach Problems		Difficult relaxing
	Phobias		Compulsive behaviors
	Obsessive thoughts		Marital/family problems
	Thoughts racing		Poor impulse control
	Can't hold onto an idea		Confusion
	Easily agitated		Difficulty trusting
	Excessive behaviors (spending, gambling)		Not thinking clearly/confusion
	Delusions/hallucinations		Spiritual Issues:
	Other problems/symptoms:		Pain (where):