# TRI-CITIES CENTER FOR CHRISTIAN COUNSELING

1111 N. Eastman Road
Kingsport, TN 37664
Phone: 423-**246-5111** Fax: 423-246-5288
www.tricitiescounseling.org



## ABOUT THE CENTER

Tri-Cities Center for Christian Counseling is a non-profit, non-denomination, Christ-centered organization employing biblical principles as a basis for counseling.

Everyone faces a variety of pressures and problems in everyday life. Sometimes these problems may grow to the point where you recognize that assistance is necessary. The counseling process is designed to lead you to a deeper level of understanding of the problem and to help you develop positive steps toward a solution. We look forward to being of service.

### ***FEES***

TCCC's fees are based on a sliding scale, and clients are to assume responsibility for meeting the counseling fee set for them. These fees cover only part of the Center's support.

We request fees to be paid before each scheduled Skype/Phone session; we do not provide billing. The secretary will handle your credit card payment over the phone when calling the office to schedule your session.

### ***SKYPE SESSIONS***

***If a session is to be missed, A 24 HOURS ADVANCE NOTICE is* REQUIRED. *A $25.00 LATE CANCEL FEE will be charged for all missed sessions.***

Counseling sessions last approximately 50 minutes. Longer sessions will be pro-rated on a 15-minute basis.

Occasionally, it may be necessary or appropriate for you to telephone your counselor. A pro-rated amount will be charged for each 15 minutes.

By signing below I acknowledge that I Have read and fully understand all information regarding the Center and requirements for Skype sessions:

Name: _____ Date: _____

Signature: _____

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## BIBLICAL COUNSELING DEFINED

By signing this document, I acknowledge my understanding that Tri-Cities Center for Christian Counseling is chartered as a Christian based facility offering Biblical counseling for people of all ages on an outpatient basis including individual, group, marriage and families. It is my understanding that they are not a mental health facility, they do not offer psychiatric therapies, psychotherapy or psychological testing of any kind and have not represented themselves as such.

Printed Name: _____

Signature: _____

Date: _____

# CLIENT'S RIGHTS AND INFORMATION

Effective communication between the client and the counselor is an important part of the counseling process. The following information covers many of the questions that may arise about counseling and includes a listing of the client's rights obligations. Any questions you may have that are not covered may be brought to the attention of your counselor.

**1.** *The Bill of Rights* of clients obtaining counseling services is as follows. It is not a legal bill of rights but a statement of what you can reasonably expect from a counselor.

**YOU HAVE THE RIGHT**

* To ask questions at any time
* To know when a counselor is available to see you, or if not, how long the waiting period would be
* To be informed of the counselors area of specialization and limitations
* To ask questions about issues relevant to your counseling
* To ask questions about written materials regarding your care
* To refuse a specific intervention or strategy
* To terminate counseling at any time

**2.** *Counseling can involve some risk for the client in certain situations*.
Sometimes the client will not obtain the desired results or goals from counseling in the time period expected. This can result in frustration and dissatisfaction. During the process of the counseling, psychological pain and distress can arise as difficult issues are addressed and worked through. The counselor may recommend referral for supplemental care when appropriate. If adequate progress is not being made or if it becomes apparent that the counselor does not have the skills necessary to address the client's issues that have emerged during counseling, the counselor may either refer for more specialized care or discontinue counseling and assist with a referral to an appropriate therapist, health care professional or therapy program.

**3.** *Confidentiality:* Confidentiality is maintained for all clients except in the following:

* If child abuse is either reported or suspected.
* When the client is a minor. The parents/guardians are entitled to know the child's condition, diagnosis, and progress.
* If the client poses a "clear and imminent danger" either to self or someone else. The counselor is required (by law) to report such danger to the appropriate parties, including family members, police, or the threatened party.
* If the client releases information with a written authorization.
* If a court subpoenas your record.
* When consultation or supervision with another counselor is desired in order to provide the best possible care. Such discussion will of course remain private within the consultation or supervisory relationship.

**4**. *Second Opinion:* If you would like a second opinion regarding your specific problems or condition, this issue should be brought to the attention of the counselor, and he/she will offer assistance in obtaining an appropriate referral.

**5.** *Discontinuation of care:* You may discontinue counseling at any time. Please feel free to discuss this with your counselor. Your counselor may also discontinue care at any time.

**6.** *Emergency:* We do not retain an answering service for 24-hour coverage. If you have an emergency, please dial 911.

**7.** *Sessions are by appointment only*. Please do not expect counseling over the phone.

By signing below I acknowledge that I Have read and fully understand my client rights and all information.

Name: _____ Date: _____

Signature: _____

**CLIENT DISCLAIMER STATEMENT**

**Please read and initial each statement to represent that you understand and agree with each statement.**

_____1. This service is not meant to be a substitute for suicidal ideation or severe psychiatric problems.

_____2. The client agrees not to hold the counselor or Counseling Center responsible or liable in any form or fashion for such actions taken of their own accord.

_____3. While **this Counseling Ministry** believes the services provided would be beneficial for you in resolving challenges of everyday living and developing yourself, there are **NO** guarantees.

_____4. I understand if I disclose that a minor is being abused, physically or sexually, the counselor is required by Tennessee state law to report such activity.

_____5. Both the client and the counselor have the right to terminate the session/sessions at any time. Also all counselors have the right, at any time, to refer the client to another of our counselors.

_____6. Under **NO** circumstance, will I take legal action against any of the counselors or the Counseling Center liable, due to advice received from the Biblical perspective that the counselor holds as Truth.

_____7. I have been given a copy of "Clients Rights" and I agree to read this information before my next counseling session, if I have not already done so.

By signing below, I testify that I have read the above and understand its contents. I **agree** to abide by the provisions set forth above.

_____ _____

**Client's Signature** **Date**

_____ _____

**Counselor's Signature** **Date**

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## CONSENT FOR ON-LINE/PHONE COUNSELING AND / OR MENTORING

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## FOR ADULTS (18 YEARS OF AGE OR OLDER)

In signing this consent, I am authorizing _____ to do on-line/phone counseling as deemed necessary or advisable for the help in my condition. I understand that the counseling I will receive is considered pastoral counseling based upon Biblical principals that the counselor holds as Truth. This consent is valid for each session I schedule unless specifically revoked by me orally or in writing.

PRINTED NAME_____

SIGNATURE _____ DATE _____

## FOR MINORS (UNDER 18 YEARS OF AGE)

In signing this consent, I am authorizing my child's counselor/mentor, _____ to do on-line/phone counseling as deemed necessary or advisable for my child's condition. I understand that the counseling I will receive is considered pastoral counseling based upon Biblical principals that the counselor holds as Truth. This consent is valid for each session my child is scheduled for unless specifically revoked by me orally or in writing.

MINOR'S NAME _____

PARENT'S SIGNATURE _____ DATE_____

# *TRI-CITIES CENTER FOR CHRISTIAN COUNSELING*

## *COUNSELING CREED*

Christian counseling is, by definition, a revelation of the life and love of Jesus Christ in helping someone change for the better no matter what issues they are facing. That life, that love comes alive in the use of the Bible and in relying upon the Holy Spirit to advance the goals and challenges of counseling. We acknowledge that we must fully rely on God's Spirit today.

In Christian counseling people are looking for spiritual help, for truth, purpose and meaning for their lives. We trust the Father to use us as an instrument in His hand to bring hope, help and healing to hurting people through His Word by the Power of His Holy Spirit.

**II Corinthians 1:3-4**

3 Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort,
4 who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.

**II Corinthians 4:7-9**

7 But we have this treasure in jars of clay to show that this all-surpassing power is from God and not from us.
8 We are hard pressed on every side, but not crushed; perplexed, but not in despair;
9 persecuted, but not abandoned; struck down, but not destroyed.

HELPING HURTING PEOPLE
IS
A REFLECTION OF GOD'S HEART

**TO DETERMINE YOUR FEE:**

(1) Your income - annual gross (before taxes) $_____

(2) Your spouse's income (if applicable) $_____

(3) Other income $_____

= TOTAL FAMILY INCOME $_____

**THE ON-LINE/PHONE COUNSELING FEE WILL BE DETERMINED WHEN THE SECRETARY SCHEDULES YOUR APPOINTMENT**

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In recognition of the service provided through Tri-Cities Center for Christian Counseling, I commit $_____per counseling hour toward it's support. I understand that if conditions of employment or other factors should warrant, the amount of this commitment may be subject to changes, *with* my approval. I realize that I will be charged a $25.00 cancellation fee for all scheduled appointments that are missed without a 24-hour notice.

I have read the above and agree to the policies and procedures of Tri-Cities Center for Christian Counseling.

Signature: _____

Date: _____

***PLEASE SIGN & FAX THIS FORM WITH THE OTHER SIGNED FORMS – THANK YOU ***

*****Please take a moment to fill this sheet out*****

**It aids in protecting your confidentiality**
**as the secretary sets up your file**
**--Thank you--**

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

_____

-IS IT OK TO RECEIVE MAIL AT THIS ADDRESS? Y N

HOME PHONE: _____

-MAY WE LEAVE A MESSAGE? Y N

CELL PHONE/ALTERNATE PHONE: _____

-MAY WE LEAVE A MESSAGE? Y N

E-MAIL ADDRESS: _____

-MAY WE E-MAIL YOU FOR FEEDBACK REGARDING YOUR COUNSELING SESSION: Y N

HOW DID YOU FIND OUT ABOUT THE COUNSELING CENTER? _____

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## POLICY FOR OPPOSITE GENDER COUNSELING

_____Due to the complexity of the unique needs of gender related issues, TCCC's Board of Directors adopted the policy of discouraging individual counseling with clients of the opposite gender. Therefore, all individual counseling sessions will be referred to a counselor of the same gender.

A. In counseling cases not involving issues of sexual abuse or sexually related issues, clients may specifically request a counselor of opposite gender. Client making the request shall be required to sign the waiver stating that they have, of their own volition, made the request to be scheduled with a counselor of the opposite gender.

B. In counseling cases involving issues of sexual abuse or sexually related issues, clients may also sign a waiver and specifically request a counselor of opposite gender, but in that instance another counselor of the same gender will be brought in as a co-counsel at an additional fee to the client.

C. In the event opposite gender counseling has begun on any case not involving sexual abuse or of a sexually related nature, and if during the course of counseling issues are identified concerning sexual abuse or sexually related issues, then at that time the client will be referred to a counselor of the same gender. The client may request to continue with the opposite gender counselor but in that event a counselor of the same gender will work as a co-counselor thereafter in the counseling process and there will be an additional fee for the co-counseling.

**I have read and understand the above policy.**

_____
(Signature)

_____
(Date)

## WAIVER, IF REQUIRED FOR YOUR CHOICE OF COUNSELOR

**I have read the above and I waive the policy that would refer me to a same gender counselor. Of my own volition I request the services of _____, a counselor of the opposite gender.**

_____ _____
(Signature) (Staff Signature)

_____ _____
(Date) (Date)

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423-246-5111

**Date**: _____

**ADULT INFORMATION SHEET** **Referred By**: _____
(Please, No Taping Of Sessions)

**NAME**: _____ _____
First Middle Last Age / DOB

**ADDRESS:** _____ _____
Full Mailing Address Telephone

*May we leave a message at your home telephone number? Yes No (please circle)*

*May we send correspondence to the above address? Yes No (please circle)*

**E-MAIL ADDRESS:** _____
*May we send correspondence to your e-mail address? Yes No (please circle)*

**OCCUPATION** _____

**EMPLOYER** _____ **TELEPHONE** _____

*May we leave a message at your work telephone number? Yes No (please circle)*

**MARITAL STATUS**: Single _____ Married _____ Separated _____ Divorced _____

***MARRIAGE:***
Present Marriage to _____ _____
Age / DOB

Spouse's Occupation _____

Number of years in present marriage. _____

Children: Names and Ages (Please state if from present or previous marriage)

_____ _____ _____

_____ _____ _____

**EDUCATION: Check if completed, enter "I" if currently involved (Optional)**

High School _____ College _____ Graduate School _____ Special Education _____

**FAMILY OR PERSONAL PHYSICIAN**

Doctor's Name _____ Telephone _____

Date of last physical exam _____

List any major diseases, physical conditions, or surgeries: _____

_____

_____

_____

_____

List any use of alcohol or drugs, including prescription and non-prescription, and state whether current or past:
_____

_____

_____

_____

_____

**RELIGIOUS BACKGROUND** _____

Church membership: (church name, if applicable) _____

Church Involvement: Active _____ Moderate_____ Inactive _____

Special Responsibilities: _____

Why did you choose a Christian Counseling facility instead of a secular facility? _____

_____

_____

_____

**Briefly state your assessment of current personal, marital or family problems:** _____

_____

_____

_____

_____

_____

_____

_____

_____

Approximately how long have these problems existed? _____

***PLEASE NOTE:***

If your session is ending at a sensitive time do you want your counselor to continue at an additional charge to you? Yes No (please circle)