

TRI-CITIES CHRISTIAN COUNSELING

225 Broad Street, Suite 2
Kingsport, TN 37664
Phone: 423-246-5111
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: _____

TRI-CITIES CHRISTIAN COUNSELING

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CONSENT FOR COUNSELING

FOR ADULTS (18 YEARS OF AGE OR OLDER)

In signing this consent, I am authorizing _____ to do 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 principles that the counselor holds as Truth. This consent is valid for each visit I make 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, _____, to do counseling/mentoring 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 principles that the counselor holds as Truth. This consent is valid for each visit my child makes unless specifically revoked by me orally or in writing.

MINOR'S NAME _____

PARENT'S SIGNATURE _____ DATE _____

UNDERSTANDING AND ACKNOWLEDGEMENT OF BIBLICAL COUNSELING

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.

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.

Printed Name: _____

Signature: _____

Date: _____

TRI-CITIES CENTER FOR CHRISTIAN COUNSELING

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

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 ***

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)