TRI-CITIES CHRISTIAN COUNSELING

225 Broad St. Suite 2
Kingsport, TN 37660
Phone: 423-**246-5111** www.tricitiescounseling.org

ABOUT THE CENTER

Tri-Cities Christian Counseling is chartered as a non-profit, non-denomination, Christ-Centered & Biblical organization incorporating Biblical principles as a basis for counseling.

Everyone faces a variety of pressures and concerns in everyday life. Sometimes these issues 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 concerns and to help you develop positive steps toward a solution. We look forward to being of service.

APPOINTMENTS

Counseling sessions last approximately 50-55 minutes. Longer session times may be pro-rated as need arises.

FEES & INSURANCE

**** We are not an insurance or mental health provider and because of our Biblical Charter, the State of TN will not allow us to file insurance or present ourselves as a medical or mental health facility in any way. Therefore, we cannot give diagnosis or procedure codes for insurance purposes.***

Our fees are based on a sliding scale, and our clients accept responsibility for meeting the counseling fee set for them.

Fees are to be paid at the time of service. The receptionist will handle payment at the ***beginning*** of each session. If the receptionist is not in, please leave the payment with your counselor.

Please Note: We are unable to accept personal checks. Debit/Credit Cards or Cash only please.

**** If an appointment is missed/cancelled. A fee of $25.00 will be charged for the appointment.***

SNOW DAY POLICY

When Schools are closed, the Center may be closed also. Please call our office to make sure your counselor can make it here, especially during inclement weather.

"NO BABY SITTING" POLICY

The Counseling Center **cannot** provide baby-sitting services or be held responsible for any unattended children. Arrangements **must** be made for children to be attended during counseling sessions.

Parents/Guardians will be held responsible for any damages or injuries due to the negligence in monitoring their own child/children.

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Date: _____

ADULT INFORMATION SHEET **Referred By**: _____
(Videos or Recording Of Sessions In Any Way Is **Not** Allowed)

NAME _____ _____
First Middle Last Age / DOB

ADDRESS _____ **PHONE** _____

*** Additional phone # where we can reach you and leave a message** _____

City: _____ State: _____ Zip: _____

May we leave a message on your voicemail? Yes No (please circle)

May we send a text to confirm your scheduled appointments? Yes No (please circle)

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

IS THIS COUNSELING COURT ORDERED? *Yes No (please circle)*
**** Additional fees will apply for letters and/or documentation to the court***

OCCUPATION _____

EMPLOYER _____

MARITAL STATUS: Single _____ Married _____ Separated _____ Divorced _____ Widow/Widower_____

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)

_____ _____ _____

_____ _____ _____

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? _____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

Approximately how long have these struggles existed? _____

PLEASE NOTE:

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

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(Required Before Receiving Counseling)

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 Biblical based facility offering counseling for people of all ages including individual, group, marriage and families. It is my understanding that they support and adhere to a Biblical view of marriage and sexuality as between one man and one woman. I acknowledge that they are NOT a medical or mental health facility; they are NOT Doctors or Psychiatrists, and have not represented themselves as such. I also understand they do NOT offer psychiatric therapies, psychotherapy, psychological testing, or evaluations, diagnosis/procedure codes or treatment plans of any kind.

PRINTED NAME_____

SIGNATURE _____ DATE _____

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 counseling issues. I understand that the counseling I will receive is considered pastoral counseling based upon Biblical principles that the facility and the counselor holds as Truth. This consent is valid for each visit I make unless specifically revoked by me orally or in writing, which will, at such time end my counseling process.

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. I understand that the counseling we will receive is considered pastoral counseling based upon Biblical principles that the facility and counselor holds as Truth.

This consent is valid for each visit my child makes unless specifically revoked by me orally or in writing, which will at such time end my and my child's counseling process.

MINOR'S NAME _____

PARENT'S SIGNATURE _____ DATE_____

CONFIDENTIALITY

Confidentiality is maintained highly for all clients, with the following **exceptions**:

* If child or elder abuse is either reported or suspected.
* When the client is a minor, the parents/guardians are entitled to know the child's progress.
* If the client poses a "clear and imminent danger" either to self or someone else. The counselor & staff are required (by law) to report such danger to the appropriate parties, including family members, police, and/or the threatened party.
* If the client releases information with a written authorization.
* When consultation with another party outside of TCC is desired, a mandatory release form must be signed prior to such discussion and will of course remain private within the conversation.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

Client Fee Sheet:

* In recognition of the service provided through Tri-Cities Christian

Counseling, I commit $ _____ per counseling hour toward it's support.

* I understand that if conditions of employment or other factors should change, the amount of this commitment may be altered.

* I understand that I will be charged a $25.00 late cancellation/no show fee for all scheduled appointments that are missed and/or cancelled.

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

Signature: _____

Date: _____