

**FAITH COUNSELING CENTER
CONSENT FOR SERVICES**

Welcome to Faith Counseling Center. Thank you for taking a few minutes to review this Consent for Services Form. Feel free to ask any questions.

PASTORAL COUNSELING COVENANT

Pastoral Counseling and psychotherapy is most helpful when it takes place in a framework of trust, clarity and understanding. Faith Counseling Center was founded to meet the need for community based pastoral counseling. Our mission as a non-pro 501 (c) 3 organization, is to be a channel of love and healing, assisting all persons to find and maintain wholeness of spirit, mind and body. The following covenant is intended to clarify and help our relationship. If you have any question about the following, please discuss them with your therapist.

FINANCIAL UNDERSTANDING

The therapy Fee Agreement that you will complete in the intake interview will state your fee and payment requirements. I understand I am responsible for payment at the time of service. Therapy time is reserved for a client. If a client does not attend a scheduled session without canceling the session in advance, the client will be charged for the session. **To avoid charges, appointments must be cancelled 24 hours in advance.**

INSURANCE AND OTHER THIRD-PARTY PAYMENTS

If you have insurance or some other third-party coverage that pays for therapy, you are responsible for giving the Center this information on the Insurance Information Form. The Center will file your claims if the information you give us is accurate and complete. The Center does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by the insurance or third-party company.

CONFIDENTIALITY

Your Rights as a Client. You have all of the rights established by the State of AZ governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, or requesting a different therapist, or ending treatment at any time, of accessing the client grievance procedures, and of having the records of your treatment kept in confidence.

Confidentiality. What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, and as part of the professional practice of this Center. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child or parental abuse; and c) if ordered by a court of law.

CONSULTATION AND SUPERVISION

For the purposes of increasing the quality of my care and for the education and supervision of my therapist, I agree that material from discussion with my therapist may be shared with appropriate Faith Counseling Center Staff, consultants and supervisors.

PERMISSIONS

My initials here _____ give permission for my sessions at Faith Counseling Center to be tape recorded.

My initials here _____ give permission for _____ to thank _____ for referring me here.

HOW TO STOP THERAPY

I understand that though I may stop therapy at any time, the ending of therapy is best if discussed with my therapist at least one session before its intended end.

CONSENT TO COUNSELING

I agree to counseling with _____ (counselor) and Faith Counseling Center.

I give my consent as parent/guardian of _____ to counseling at Faith Counseling Center.

Signed _____ Date _____ Witness _____