Covenant
COUNSELING CENTER

441 Clay Street, Suite 2
Kingsport, TN 37660
Email: covenantkpt@gmail.com

423-765-0607
Fax: 423-247-1117

Welcome to Covenant Counseling Center (CCC)! CCC is a non-profit organization that originated as a ministry of First Baptist Church, in an effort to meet some of the mental health needs of the community. **Our mission is to provide professional clinical counseling services to individuals, couples, and families in a Christian environment.** This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

Clinical Training Site: **Initial here**: _____
Covenant Counseling Center is a clinical training site for graduate students in marriage & family therapy and/or professional counseling.
Would you be willing to see an intern? Please circle: YES / NO
Would you be willing to have an intern sit in with you and your therapist? Please circle: YES / NO

Appointments: **Initial here**: _____
Appointments are usually scheduled for 50 minutes and are made by the therapist and/or the CCC office manager at (423) 765-0607. The frequency of visits will vary depending on your individual needs and the availability of your therapist. The practice hours will vary by clinician. However, office hours for appointments are usually Monday through Friday between the hours of 9 a.m. and 7 p.m. **If an appointment is missed or is canceled with less than a 24-hour notice, you will be billed $25.00 which will not be covered by insurance**. Anyone who misses more than 3 appointments without appropriate notification within a 12-month period may be discharged and referred elsewhere for treatment. You may discontinue treatment at any time, but you are asked to notify your therapist of your decision.

Fees: **Initial here**: _____
You are responsible for payment at each session. Payment is expected at the time of your session unless other arrangements have been made in advance. Payments should be made payable to Covenant Counseling Center.
Sliding Scale Option: In an effort to make counseling affordable, CCC offers a **sliding scale** as one of the payment options you may choose to utilize. The fee for service is based on income. Please refer to the **sliding scale**, which lists your yearly total household income.

Annual Household Income	Hourly Fee
$35,000 and Below	$35.00
$35,001-$50,000	$50.00
$50,001-$65,000	$65.00
$65,001-$80,000	$80.00
$80,001-$100,000	$100.00
$100,001-$125,000	$125.00

If you have opted to utilize the sliding scale method to determine fee for service, please insert the appropriate total household income here: $_____ & fee amount here: $_____. **Initial here**: _____

Additional Billable Services: You may also be billed for any other services such as telephone conversations lasting more than 5 minutes, interventions outside of the therapy session, or completion of forms or letters requested on your behalf at a prorated $125 per 50 minutes**.**

Insurance Option: Another option available at CCC is to utilize your insurance carrier which may pay for a portion of the fee. The therapists vary on insurance carriers for which they are providers. It is your responsibility to find out your mental health benefits and if the individual therapist is a provider for your particular health plan. If you opt to use your health coverage, the billing fee each 50-minute therapy session is **$125**. It is your responsibility to obtain prior authorization for treatment from your insurance carrier. If your insurance does not pay for some reason, you are responsible for the bill.

Treatment Philosophy: **Initial here: _____**

Brief therapy is goal-directed, solution-focused treatment. Each therapist may utilize different theoretical approaches and will discuss with you the benefits and goals involved. You will be expected to assume an active role in the treatment process. Although the course of your treatment is designed to be helpful, the therapist cannot make any guarantees about the outcome of your treatment. Although there are believed to be many benefits of counseling, people tend to make changes in the course of treatment which can be uncomfortable and challenging. Certain diagnoses can result in preexisting conditions in the future for insurance coverage. Treatment records are not written in a manner which serves to be helpful to support disability claims. CCC **does not perform** Child Custody Evaluations.

Limits of Confidentiality Statement: **Initial here: _____**

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged". However, there are limits to the privilege of confidentiality**.** These situations include:

1. Suspected abuse or neglect of a child, elderly person, or a disabled person
2. When your therapist believes you are in danger of harming yourself or others. If you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities.
3. If your therapist is ordered by a court to release information as part of a legal involvement in litigation, etc.
4. When your insurance company or another third-party payee is involved.
5. As a result of a natural disaster whereby protected records may become exposed.
6. When otherwise required by law.
7. When you sign a Release of Information giving your permission for the therapist to share your protected information with a designated person.

Record Keeping: **Initial here: _____**

Active charts are double locked and on site. A clinical chart is maintained describing your condition, treatment, dates of services, and progress notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Complaints: **Initial here: _____**

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform us immediately and discuss the situation. You have the right to submit a grievance to your therapist at any time during care or to directly to the State of Tennessee LPC and LMFT Licensing Board.

Emergency Access: **Initial here: _____**

In an emergency you are instructed to call 911 or go to a local ER. Your individual therapist will instruct you how you may access him/her. Each therapist is responsible for managing his/her case load in emergency after hours. If you are unable to access your individual therapist, one of the other therapists in the office may assist you in a crisis. You may also call Respond at 1-800-366-1132.

Client Consent for Treatment:

You are hereby consenting to treatment with _____ until you otherwise notify CCC. By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction. You accept, understand and agree to abide by the contents and terms of this agreement.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

Parent/Guardian Consent for Child or Dependent Treatment:

You are reporting that you have legal responsibility for, (*name of child*) _____ and you consent to treatment with *(name of therapist)* _____ to see previously mentioned child with and/or without you being present in the same session. You understand that you are the holder of confidential privilege-the right to withhold disclosure of private information about your child. However, in the interest of developing a trust relationship between the therapist and your child, you give the therapist permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and protect your child.

_____ _____

Signature of Parent/Legal Guardian **Signature of Parent/Legal Guardian**

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Today's Date: _____ /_____ /_____

Client Full Name:

Address: City/State/Zip:

Client's Date of Birth: Social Security Number:

Home Phone: Cell Phone:

Work Phone: Email:

Which number(s) may we use to contact you? Please circle: ☐ Home ☐ Cell ☐ Work

At which number(s) may we leave a message? Please circle: ☐ Home ☐ Cell ☐ Work ☐ None

May we contact you via: Mail? ◯ YES ◯ NO Text Message? ◯ YES ◯ NO Email? ◯ YES ◯ NO

If yes to text or email: I understand that text/email transmissions may not be secure and will not be used for the purpose of communicating my personal health information. Client signature: _____

Occupation: _____ Place of Employment: _____

Gender: Ethnicity: Marital Status:

Spouse/Parent/Guardian:	**Emergency Contact Person:**	**Name of Physician:**
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Office Location: _____
_____	_____	_____
Date of Birth:	Phone: _____	Phone: _____
Phone:		Last Physical Exam:____/____/_____

Person Financially Responsible: _____

Phone #: _____ Address:

Do you have medical/health insurance? ◯ YES ◯ NO If so, what insurance company?

Known Allergies?

Medical Problems/Other Diagnoses:

Current Medications & Dosage (including supplements):

Legal Issues:

Who may we thank for referring you to Covenant Counseling Center? _____

Are you a member of or affiliated with any of our Covenant Partners? Please check all that apply:

□ First Baptist Church of Kingsport	□ Central Baptist Church of Kingsport	□ Calvary Church of Johnson City
□ First Baptist Church of Blountville	□ Central Baptist Church of Johnson City	□ Shades of Grace UMC
□ Christ Fellowship Church	□ First Presbyterian Church of Kingsport	□ Temple Baptist Church
□ Recovery at Clay Street	□ Providence Medical Clinic	□ Crossroads Medical Mission

Religious/Faith Affiliation:
Do you consider your faith/religion meaningful in your life? ◯ YES ◯ NO

Briefly describe the reason(s) you are seeking counseling:

Previous Mental Health Services:

Type of Service	Provider	Date(s) of Service

Are you currently seeing a psychiatrist or another therapist? ◯ YES ◯ NO

Name of Psychiatrist / Therapist:
Have you ever received counseling at Covenant Counseling Center or First Baptist Counseling Center? ◯ YES ◉ NO
Name of therapist:

To authorize your new Covenant Counseling Center therapist access to your previous counseling records with us, please sign here:

Symptoms currently experiencing:

□ Depressed Mood	□ Racing Thoughts	□ Family Problems
□ Anxious Mood	□ Suicidal Thoughts	□ Relationship Problems
□ Isolation	□ Homicidal Thoughts	□ Academic Problems
□ Poor Concentration	□ Worrying Thoughts	□ Work Problems
□ Crying Episodes	□ Feeling Worthless	□ Hygiene Problems
□ Irritability	□ Sleep Problems	□ Appetite Problems
□ Low Energy	□ Insomnia	□ Food Restriction
□ Low Self-Esteem	□ Hypersomnia	□ Binging
□ Impulsive Behavior	□ Panic Attacks	□ Purging