

The Counseling Center at Davidson United Methodist Church  
P.O. Box 718  
233 South Main Street  
Davidson, North Carolina 28036  
Phone: 704-892-6135 Fax: 704-892-5029

PASTORAL COUNSELING AGREEMENTS AND DISCLOSURES

**FINANCIAL UNDERSTANDING**

I understand that the fee for a 45-50 minute session at The Counseling Center is \$115. I have discussed my ability to pay with my therapist, and have agreed to pay \$\_\_\_\_\_ per session. My fee may be renegotiated if my income increases or decreases significantly.

I will pay for my sessions at each visit. I understand that appointments rescheduled or cancelled without 24 hours notice (by noon on Friday for Monday appointments) will be charged at my agreed-upon fee.

**LIMITS OF CONFIDENTIALITY**

I understand that my therapist will hold all aspects of my therapy in strictest confidence, as mandated by law. I also understand that my therapist is required by law to report any suspicion of abuse or neglect of children, disabled persons, and the elderly as well as any intent to harm oneself, another, or property. My therapist may also be required to disclose confidential information if a court order is issued.

**CONSULTATION AND SUPERVISION**

For the purposes of increasing the quality of my care and for the education and supervision of my therapist, I understand that relevant issues from my therapy may be shared with appropriate clinical Counseling Center staff, consultants, and supervisors.

**PERMISSIONS**

\_\_\_\_\_ My initials here give permission for The Counseling Center to thank \_\_\_\_\_ for referring me here. I understand that a release of information form must be signed for my therapist to give any additional information.

\_\_\_\_\_ My initials here give permission for The Counseling Center to leave messages on my home/work/cell (circle all that apply) phone answering machine that mention the name of their agency.

\_\_\_\_\_ My initials here give permission for The Counseling Center to send/reply to emails from the following email address:\_\_\_\_\_. I understand that email should not be used for emergency or time-sensitive issues. I also understand that the privacy and security of e-mail is not guaranteed and I will not hold The Counseling Center at Davidson United Methodist Church responsible for information loss due to technical failures.

\_\_\_\_\_ My initials here give permission for The Counseling Center to mail a Client Evaluation of Services to me once my therapy process is complete.

**LIMITS OF AVAILABILITY**

I understand that The Counseling Center has no on-call or pager system. Phone calls will be returned within 24 hours, usually by the end of the day. Messages left after hours or on weekends will be returned the next business day. If I am in a medical or psychiatric emergency and cannot wait for a return call from my therapist, I understand that I may contact Carolinas Healthcare's Behavioral Health 24-hour coverage line at 1-800-418-2065, call 911, or proceed to my local emergency room.

**CONSENT TO COUNSELING**

I understand that the process of growth and change that occurs in therapy may sometimes include emotional pain, unpleasant memories, and periods of temporary impasse. To the best of my ability, I agree to openly discuss such issues with my therapist, \_\_\_\_\_. I understand that if at any point I feel that I have been harmed or mistreated, and efforts to discuss this with my therapist are unsatisfactory, I may contact the Director of The Counseling Center for appropriate grievance procedures.

\_\_\_\_\_  
Signed (Client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed (Parent or Guardian, if necessary)

\_\_\_\_\_  
Date