**Crossroads Center for Christian Ministries, Inc.**

5283 Bells Ferry Road Suite 300 Acworth, Georgia 30102

INFORMED CONSENT

**Limitations of Confidentiality:** It is understood and agreed that all statements, whether written or verbal, with your counselor are of a confidential nature and ethically cannot be disclosed, without written consent, with the following exceptions that will result in confidentiality being waived.

**1. Suspicion of child/elder abuse** – We reserve the right and/or may be mandated by law to report child abuse or suspicion of child/elder abuse of any type to the proper authorities and or the right to cause a report of child/elder abuse to occur.

**2. Threats to harm self or others** – We reserve the right and /or may be mandated by law to disclose to the appropriate person, agency or civil authorities any threat of harm that a person may tempt or desire to do to one’s self or to others.

**3. Necessity of consultation** – We reserve the right to consult with other counseling professionals regarding your session. This consultation will be held in the same level of confidence as your sessions.

**Waiver of Liability:** Crossroads Center for Christian Ministries, Inc. (CCCM, Inc.) specifically disclaims any liability, personal or otherwise, incurred as a consequence of your session with Karen McDonald. Unless absolutely necessary for the physical or psychological safety of yourself or your child, the undersigned will neither request nor require testimony in court. The reason for this is so that treatment is not compromised and the therapeutic relationship with the client and family is maintained and the client experiences the therapist in a clear, consistent, therapeutic role and not as an assessor or detective.

**Counseling Files:** All counseling files and the content s belong to CCCM, Inc.

**Fee Schedule:** Cost of our services is $100.00 per counseling hour. Fee is paid at the end of each session. This office does not handle insurance. Fee may be paid by cash, check, Visa, Master Card or Discover credit or debit card. If you insurance policy covers mental health care out-of-network, they may reimburse you directly. Please discuss this further with your counselor.

**Telephone Calls:** Any telephone conversation lasting longer than 10 minutes will incur a regular session fee.

**Cancellations or Reschedules:** If you need to reschedule or cancel an appointment we ask that you call at least 24 hours in advance. This allows us to reschedule others who may be waiting for an appointment. When you fail to keep your appointment without cancellation, neither I nor anyone else can use that time reserved for you. Therefore, cancellation less than 24 hours in advance will result in a $50.00 cancellation fee. No-shows or cancellation within the hour of your appointment will incur the regular session fee, since I will be at the office waiting for you.

**What is expected of you?** It is our belief that change must begin with ourselves as we look to Christ for the power to change. Therefore, we ask you to approach the counseling process as an opportunity for personal change and spiritual growth. We ask that you refrain from the temptation of focusing on changing others, and instead ask you to focus on what changes God desires to make in your life in the midst of your circumstances.

I have carefully read this information sheet and agree to all of the stated terms and conditions. I also agree that all the information on my personal data form is true and complete to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME (PRINTED)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE

COURT APPEARANCES

CCCM, Inc. requires that you review and sign this separate financial agreement concerning court appearance.

My role as your therapist or your child’s therapist is to maintain an atmosphere of trust and guidance. When I meet with you or your child, it is in the hope that my role will remain separate from your legal issues with a spouse, perpetrator, etc. Whenever litigation involves my testifying, our relationship as client/counselor is compromised. There is a difference between being the professional who assists the person to move forward in their life and does therapy, versus a professional who evaluates for forensic purposes.

Oftentimes there are unintended consequences to my testifying. Some of what is said in session you might now want repeated and if I am under oath, with you (the client or parent of the client) having waived the client/therapist privilege, then I cannot lie or withhold answer to questions posed tome as your therapist.

Having said that, there are times when my testimony may be in the best interest of you or your child. If I am subpoenaed for court or requested to testify in court, be advised there is a flat fee of $1000.00 for each local court appearance, which must be paid prior to serving me with a subpoena. For courts outside a 50 mile radius of my office, there is an additional $100.00 per hour travel fee.

If I am asked to write letters, reports, and do things in addition to hourly therapeutic services there are additional fees you will be required to pay in advance. Be advised that you cannot bill your insurance for my court time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client or parent’s signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date

INTAKE SHEET/PERSONAL DATE

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of cancellation or reschedule, may we contact you at any of the above phone #’s or email?

Religious background if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your present spiritual beliefs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which church do you attend, if any? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you an adopted child? \_\_\_\_\_\_\_\_\_\_\_ If yes, at what age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Engaged Married Divorced Separated Widowed Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Married how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This is your (1st, 2nd, etc.) \_\_\_\_\_\_\_\_\_marriage. Your spouse’s \_\_\_\_\_\_\_\_ marriage. Have you or your spouse ever been sexually or physically abused? By whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of children Indicate children from a previous marriage or stepchildren with an \*

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

What is the specific problem or concern that has caused you to seek out counseling at this particular time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING PROBLEMS**

Please state, in your own words, the problems you are experiencing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal in counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the use/abuse of drugs and /or alcohol related to this problem in any way? If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any significant loss/crisis/life change recently?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any descriptions of what you are currently experiencing.

Anxiousness Depression Anger

Confusion Fear Loneliness

Despair Thoughts of suicide Hurt

Guilt/shame Withdrawing from others Distance from God

Marital distress Parenting struggles Relational stress

Your childhood issues Domestic violence Victim of abuse or crime

Adoption issues Spiritual confusion Adult child of alcoholic parent

GENERAL HEALTH, COUNSELING, AND LEGAL DATA

Are you now under a physician’s care: If so, for what kinds of problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently taking any prescription or non-prescription medications?\_\_\_\_\_\_ Please indicate type and dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you aware of any physical problems that impair your functioning? \_\_\_\_\_\_\_\_\_\_\_

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or been in an outpatient program for emotional issues or substance abuse? \_\_\_\_ If yes, please list when, where and for what issues.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving or have you in the last 3 years received individual or marital therapy, or been under the care of any mental health provider or addiction recovery provider? Provider name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you feel us contacting this provider for additional information will be helpful to you, you will need to fill out an additional release form.

Are you currently involved in, or anticipate being in any litigation or legal action? \_\_\_\_\_\_\_\_\_

Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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