

METHODIST COUNSELING & CONSULTATION SERVICES
1801 East Fifth Street, Suite 110
Charlotte, N.C. 28204-2472
704-375-5354

Pastoral Counseling Covenant

Pastoral Counseling and psychotherapy are most helpful when they take place in a framework of trust, clarity, and understanding. This covenant is between MCCS and you with your therapist being the direct provider of care as the representative of MCCS. This covenant is intended to clarify and help this relationship. Should you have any questions concerning this covenant, please discuss them with your therapist.

Financial Understanding

I/we understand that the fee for a 50 minute session at MCCS is **\$125.00** and that the fee for the initial visit is **\$150.00**. I have discussed this amount with the therapist along with my ability to pay.

I agree to a fee in the amount of _____.

If I choose to use my insurance benefits to offset the cost of my therapy, then I understand that the full fee will be charged. I agree to be responsible for that full fee amount, and I will pay at each visit my required co-pay or the full fee until my deductible is met.

Cancellation Policy

I understand that I will be charged the full fee of **\$125.00 for a missed appointment or if I fail to cancel without 24 hours notification**. This can be discussed with your therapist if special circumstances result in a missed appointment.

Limits of Confidentiality

I understand that while confidentiality is central to the process of therapy, it must be broken and a report made to the proper authorities when there is abuse or neglect of children, disabled persons, and the elderly; when there is intent to harm oneself, another, or property; or when 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 agree that material from discussions with my therapist may be shared with appropriate MCCS staff, Psychiatric consultants, and supervisors.

Permissions

Some staff therapists may be completing additional certification and/or licensure and may request to record sessions while maintaining the above **Limits of Confidentiality** for **Consultation and Supervision**.

My initials here _____ indicate I give permission to tape my sessions. I recognize that I may suspend this permission at any time.

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

Terminating 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 it ends.

Consent to Counseling

I understand that there are certain risks in therapy and that there may be alternatives to therapy. I agree to counseling with _____ and MCCS.

Signed _____

Witness _____

Signed _____

Witness _____

Date _____

Date _____