

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 M CCS and you with your therapist being the direct provider of care as the representative of M CCS. 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 M CCS is **\$110.00** and that the fee for the initial visit is **\$130.00**. 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 **\$110.00 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 M CCS 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 M CCS.

Signed _____

Witness _____

Signed _____

Witness _____

Date _____

Date _____