Mission Statement

Branches is a faith-based counseling center that seeks to provide help for people of all faiths that are hurting emotionally, spiritually, and physically, especially those suffering from the effects of depression, addiction, marriage/family issues, and shame, and any other life concerns. We desire to be a positive influence for wholeness both in Middle Tennessee and beyond.

While we cannot separate our mission from our faith we offer our services to all people regardless of race, creed, religion, or gender. Faith will never be forced on an individual and our approach to such matters will always be respectful and appropriate. We will open such spiritual helps as prayer and scripture only with permission and make no discrimination on the care we give based on your response.

We also seek to meet the needs of our world without economic or geographic boundaries. To this end we pledge integrity, accountability, and equal treatment in all of our financial discussions and decisions.

I have read and understand the above information.

_____ _____

Patient / Guardian Signature Date

What is the primary reason for seeking counseling?

What do you desire to gain from counseling?

CLIENT APPLICATION		
Name:		
Date of birth:	E Mail:	Phone:
Current address:		
City:	State:	ZIP Code:
Alt. Phone:	Preferred Contact:	SS#:
COUNSELING INFORMATION		
Counselor:		
Type of Counseling:		Hourly Fee: $90.00
Frequency:	Scholarship:	
Payment Type:	First and Last Name on Card:	
Credit Card No.		Address of Cardholder:
Exp. Date:		
Signature Authorizing Use of Card:		
EMERGENCY CONTACT		
Name of a relative not residing with you:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
SPOUSE INFORMATION IF COUPLES		
Name:		
Date of birth:	E Mail:	Phone:
SPOUSE CONTACT INFORMATION IF DIFFERENT		
Current address:		
City:	State:	ZIP Code:
Alt. Phone:		
INSURANCE INFORMATION		
Name of Insured:	SS# of Insured:	Group No.:
Address:	Employer:	Policy No.:
City/ST:	DOB of Insured:	Co- Pay:
CHILDRENIF INCLUDED IN COUNSELING		
Name	Name	
Name	Name	
SIGNATURES		
I authorize the verification of the information provided on this form as to my credit		
Signature of applicant:		Date:
Signature of spouse*(only if for a joint membership):*		Date:

Consent to Treat

Please fill out and sign / date where indicated.

Client:

Name_____ **Date of Birth**_____

Address_____ **Phone**_____

_____ **SS#**_____

Consent to Treat

I, _____ do hereby consent for the staff at Branches to provide services to me
(Please Print)
or to my dependent. I understand that all services are voluntary. I affirm that I am a willing participant.
Without signature, we are unable to provide services.

_____ _____
Patient / Guardian signature Date

Primary Care Physician

For coordination of care, we request that you provide the name of your primary care physician. We will contact your physician to inform of the services that you will receive here. This information along with your signature gives us authorization to contact your primary care physician, as required, in regards to your treatment.
If you do not have a primary care physician or you do not want us to make contact please leave this area blank.
Physician Name_____ Phone_____

Address _____

_____ _____
Patient / Guardian Signature Date

Referral Source

We would like to thank whoever referred you to this office. By providing the following information and with your signature, this gives us authorization to send a "Thank you" letter to the referral source from this office.
If you do not wish us to do this, please leave this area blank.

Person who referred you _____ Phone_____

Address _____

_____ _____
Patient / Guardian Signature Date

Client Name_____

Confidentiality

This is to inform you that all services received in this office are strictly confidential. Without your written consent for release of information your participation in services provided at this office will not be confirmed or denied nor will any other information be released. There are certain exceptions to confidentiality. Please ask you service provider for more information.

_____ _____
Patient / Guardian Signature Date

May we call your home or work, recognizing ourselves as Branches Counseling Center at :
Home: Yes No Work: Yes No (Circle one each)

May we talk to whoever answers, recognizing ourselves as Branches Counseling Center at :
Home: Yes No Work: Yes No (Circle one each)

May we leave a message, recognizing ourselves as Branches Counseling Center at :
Home: Yes No Work: Yes No (Circle one each)

_____ _____
Patient / Guardian Signature Date

Authorization for Release of Information

I hereby authorize Branches Counseling Center to furnish information to staff counselors concerning my illness and treatment. I further authorize the transfer of records from/to Branches Counseling Center and Insurance companies until such permission is canceled in writing by me.

_____ _____
Patient / Guardian Signature Date

_____ _____
Witness Date

Cancellation/ Check Return

Please be advised that there is a **$50** charge for appointments not cancelled at least 24 hours in advance. This charge also applies should you not show for an appointment without canceling at least 24 hours beforehand. This charge will **not** be billed to insurance. The payment for the charge is **your** responsibility. Payment for missed appointments is expected at the next office visit, and you will not be seen again until payment is received. It is your responsibility to keep up with scheduled appointments. You will not be called to remind you of your appointment. This policy ensures that you will receive timely treatment in the most efficient way possible.

We accept cash, checks or VISA/MasterCard. If you wish to pay by credit card, simply fill out the information below. Your card will be charged at the end of each session for that session only. *There is a $20.00 fee for checks that are returned due to non-sufficient funds.*

I have read, agree to, and understand the cancellation and check return policy.

_____ _____
Patient / Guardian Signature Date