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 INFORMATION		
Name:		
Date of birth:	E Mail:	Preferred Phone:
Current address:		
City:	State:	ZIP Code:
Alt. Phone:		SS#:

EMERGENCY CONTACT (PARENT/GUARDIAN INFO IF CHILD CLIENT)		
Name of emergency contact person:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

SPOUSE INFORMATION (IF FOR COUPLES COUNSELING)		
Name:		
Date of birth:	E Mail:	Phone:

SPOUSE CONTACT INFORMATION (IF DIFFERENT FROM ABOVE)		
Current address:		Phone:
City:	State:	ZIP Code:
Alt. Phone:		

CHILDREN (IF INCLUDED IN COUNSELING)			
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

INSURANCE INFORMATION (IF USING INSURANCE)		
Name of Insured:	SS# of Insured:	Group No.:
Address:	Employer:	Policy ID No.:
City/ST:	DOB of Insured:	Co- Pay (if known):

SIGNATURES	
I declare that the information provided by me on the above form is true and correct to the best of my knowledge and belief:	
SIGNATURE OF CLIENT/GUARDIAN:	Date:
Signature of spouse *(only if for couples counseling):*	Date:

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.

_____ _____
Client / Guardian Signature Date

Primary Care Physician

For coordination of care, we request that you provide the name of your primary care physician. We may 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 _____

_____ _____
Client / Guardian Signature Date

Referral Source (Check all that apply):

Where did you hear about Branches?

- ☐ Church leader
- ☐ Community event
- ☐ Family or friends
- ☐ Insurance company
- ☐ Internet search
- ☐ School staff
- ☐ Social Media
- ☐ Medical Provider
- ☐ Other: _____

Why did you choose Branches?

- ☐ Affordability
- ☐ Appointment availability
- ☐ Faith-based approach
- ☐ Location
- ☐ Reputation in the community
- ☐ You accept my insurance
- ☐ Other: _____

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 which are listed below. Please ask your counselor if you have questions or need more information.

- If your counselor believes that you are likely to harm yourself and/or another person, he or she may take action necessary to protect you or others by contacting law enforcement or crisis services.
- If your counselor has cause to believe that a child has been or may be abused or neglected, the counselor is required to make a report to the appropriate state agency.
- If your counselor has cause to believe that an elderly or disabled person has been or may be abused, neglected, or subject to financial exploitation, the counselor is required to make a report to the appropriate state agency.
- If your records are requested by a valid subpoena or court order, we must respond.
- If the client is a minor (under the age of 16). Tenn. Code Ann. § 33-8-202

_____ _____
Client / Guardian Signature Date

Client Name_____

Informed Consent regarding Electronic Communication

It may become useful during the course of counseling to communicate by email or other electronic methods of communication. Be aware that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Branches, there is a chance that a third party may be able to intercept these messages. Should you use any of these types of communication to contact Branches then it is understood that you are consenting to communicating by these means. By signing below, you are acknowledging that you understand and accept these risks.

_____ _____
Client / Guardian Signature Date

May we call the phone numbers you provided, recognizing ourselves as Branches Counseling Center?
☐Yes ☐ No

May we talk to whoever answers at the phone numbers you provided, recognizing ourselves as Branches Counseling Center?
☐Yes ☐ No

May we leave a message at the phone numbers you provided, recognizing ourselves as Branches Counseling Center?
☐Yes ☐ No

_____ _____
Client / Guardian Signature Date

Authorization for Release of Information

I hereby authorize Branches Counseling Center to share my information, relevant to my treatment, within the Branches organization. I further authorize the transfer of my records, relevant to my treatment, from/to Branches Counseling Center and my insurance company (when using insurance) until such permission is canceled in writing by me.

_____ _____
Client / Guardian Signature Date

_____ _____
Witness Date

Cancellation/Payment/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 **cannot** be billed to your insurance. The payment for the charge is **your** responsibility. Payment for missed appointments will be charged before your next appointment and you will not be seen again until payment is received. It is your responsibility to keep up with scheduled appointments. Appointment reminder emails may be sent but these should not be counted upon as your only reminder. You will not be called to remind you of your appointment. Appointments begin on the hour and last 45-50 minutes. Should you not arrive within 15 minutes of your appointment time you may be asked to reschedule for a later date and this appointment will be billed as a late cancellation. This policy ensures that you are present for each of your appointments and so 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 on your sign in sheet or let one of the front desk attendants know. Your card will be charged at each session for that session or for a Late Cancellation or No Show Fee. *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, payment, and check return policy and authorize the use of my card on file for payments.

_____ _____
Client / Guardian Signature Date