



**INTENSIVE APPLICATION**

The 5-day Intensive Program at Branches is designed to help you move forward. Pause your life for just five days and we will help you dig deep to see what is at the heart of the problem that is keeping you down. We shape a 5-day schedule with you in mind. Each session will fit together to help you see a new future with possibilities and hope.

The purpose of the Intensive is to minimize pain, restore hope, and develop a concrete plan for moving forward for those who suffer from depression, trauma, grief or loss, anxiety, addiction deep spiritual issues and more. We create a 5-day program that is designed to address your personal, specific needs. This program treats the whole person – mentally, physically, and spiritually. One-on-one counseling, EMDR, group sessions, prayer, and personal assignments may be included. Before you leave we will help you develop a long-term recovery plan with tools to help you cope. You will leave with new insights and understanding about yourself.

While we cannot separate our mission from our faith, we offer our services to all people regardless of race, creed, religion, or gender. Because we are faith-based, we will open such spiritual helps as prayer and scripture, but only if that is something you are comfortable with. Faith will never be forced on an individual and our approach to such matters will always be respectful and appropriate.

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 our financial discussions and decisions.

*I have read and understand the above information.*

\_\_\_\_\_  
**Client 1 signature** | *if individual* \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 signature** | *if couple* \_\_\_\_\_  
**Date**

*Branches is a Christ-centered ministry that facilitates healing and hope for the whole person – mentally, physically & spiritually.*



**BRANCHES**

*Recovering Hope • Restoring Lives*

**CLIENT QUESTIONNAIRE**

*Please answer the following questions thoroughly.*

**What is your primary reason for applying for this Intensive Program?**

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**What are your specific goals and expectations for your time at Branches?**

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**Please tell us anything else that you would like us to know.**

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## CLIENT INFORMATION

*Please read and complete this form entirely.*

\_\_\_\_\_  
**Client 1 Full Name** | *if individual*

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Gender**

\_\_\_\_\_  
**Client 2 Full Name** | *if couple*

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Gender**

\_\_\_\_\_  
**Home Address**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

\_\_\_\_\_  
**Client 1 Phone**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Client 1 Social Security #**

\_\_\_\_\_  
**Client 2 Phone**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Client 2 Social Security #**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Billing Address associated with Payment Method if different than above**

## PRIMARY CARE PHYSICIAN

For coordination of care, we request that you provide the name of your Primary Care Physician. When needed, we will contact your physician to inform him or her 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, regarding 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's Name**

\_\_\_\_\_  
**Office Phone**

\_\_\_\_\_  
**Office Address**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**

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**CONSENT TO TREAT**

I, \_\_\_\_\_ and \_\_\_\_\_ do hereby consent for the staff at Branches to provide services to me. I understand that all services are voluntary. I affirm that I am a willing participant.

*Without signatures, we are unable to provide services.*

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**

**RELEASE OF INFORMATION**

I hereby authorize Branches Counseling Center to furnish information to staff counselors concerning my treatment.

*Without signatures, we are unable to provide services.*

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Branches Representative Signature**

\_\_\_\_\_  
**Date**

**REFERRAL SOURCE**

*Please select as many of the responses that apply to you.*

<b>Where did you learn of Branches' Intensive Program?</b>	<b>Why have you chosen Branches' Intensive Program?</b>
<input type="checkbox"/> Church Leader	<input type="checkbox"/> Affordability
<input type="checkbox"/> Community Event	<input type="checkbox"/> Faith-based Approach
<input type="checkbox"/> Family or Friend	<input type="checkbox"/> Location
<input type="checkbox"/> Internet Search	<input type="checkbox"/> Reputation
<input type="checkbox"/> Social Media	<input type="checkbox"/> Length of Program
<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Availability
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

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## CONFIDENTIALITY AGREEMENT

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 your service provider for more information.

\_\_\_\_\_  
Client 1 Signature | *if individual*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client 2 Signature | *if couple*

\_\_\_\_\_  
Date

*Please read each question below and mark the box accordingly.*

**May we call the phone number(s) you provided, recognizing ourselves as Branches Counseling Center?**

Client 1:  Yes  No

Client 2:  Yes  No

**May we talk to whoever answers at the phone number(s) you provided, recognizing ourselves as Branches Counseling Center?**

Client 1:  Yes  No

Client 2:  Yes  No

**May we leave a voicemail message at the phone number(s) you provided, recognizing ourselves as Branches Counseling Center?**

Client 1:  Yes  No

Client 2:  Yes  No

\_\_\_\_\_  
Client 1 Signature | *if individual*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client 2 Signature | *if couple*

\_\_\_\_\_  
Date

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## COUNSELING SERVICE AGREEMENT

*Each participant must initial each statement as proof that you have read and understand this service agreement.*

Our staff is made up of Licensed Professional Counselors, Pastoral Counselors, and Life Coaches. Pastoral Counselors are under a different mandate and approach the counseling process from a different standpoint. This agreement for counseling services shall govern all professional relations between the parties.

- Our Licensed Professional Counselors are licensed by the state of Tennessee with a Mental Health Service Provider designation (LPC-MHSP).
- Our Pastoral Counselors are ordained counselors licensed by the NCCA as Pastoral Counselors. They are not state-licensed therapists, nor are they affiliated with any state agency. They are held to strict academic, ethical, and moral standards by the licensing board of examiners with the National Christian Counselors Association.
- Pastoral counseling at Branches Counseling Center is Christian counseling. It should be investigated by the client and determined to be in their best interest before signing a commitment. Our counselors are trained and experienced in both pastoral and counseling ministry.
- Life coaches are certified as a life coach but are not considered counselors but are individuals who are taught to help people develop and achieve goals for the future.
- Fees - A \$500 non-refundable deposit must be made at least 4 weeks prior to the start of the intensive.
- Confidentiality Policy – All therapeutic communications and records will be held in strict confidence. Information may be released, in accordance with the state law.
  - 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.

*Although it cannot be guaranteed, it will be endeavored to inform clients of all mandated disclosures. Clients with any concerns or questions about this policy agree to raise them with their counselor at the earliest possible time to resolve them in the client's best interest.*

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Work Agreement – It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Client gain and self-respect is most important in counseling. Suspension, termination, or referral shall be discussed between counselor and client for a pattern of behavior that reveals disinterest or lack of commitment to counseling or for any unresolved conflict or impasse between counselor and client.

It is agreed that any disputes or modifications of agreement shall be negotiated directly between the parties; if negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator, considering first either a Pastor or other Minister of the client’s or counselor’s church.

*We, the undersigned counselor and client, have read and fully understand this Counseling Service Agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another’s views and differences in their outworking. We have also agreed to an initial definition of counseling work and to the fee to be paid by the client. By signing below client acknowledges that he/she is fully responsible for any decisions he/she makes regarding his/her life and circumstances and hereby absolves the counselor from any and all liability regarding the counseling that is provided.*

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Branches Representative Signature**

\_\_\_\_\_  
**Date**



**INTENSIVE PAYMENT PLAN**

It is the desire of **Branches Counseling Center** to assist you by providing professionally trained Christian counselors for an intensive program. To keep this Christian practice viable, we do our best to establish a fee that is as minimal as possible. Our fee for a one-week intensive is \$2900. If that is not possible, please talk to our intensive coordinator and discuss other options.

In Branches Counseling Center’s desire to improve the affordability of the Intensive program, a payment plan has been developed to allow total payment over a 12-month period. It is necessary for the participant to make a non-refundable down payment of \$500 to secure your place in the program. Thereafter, a 12-month payment plan can be developed, the balance to be paid on the first of each month for 12 consecutive months. In short, your payment plan will be as follows unless otherwise discussed. In which, that will be detailed below:

**TOTAL COST:** \$2,900.00

**Please keep in mind that this Intensive Program is NOT insurance reimbursable.**

**DOWN PAYMENT:** \$500.00 non-refundable payment due at least 4 weeks prior to the start date of your scheduled intensive.

**BALANCE:** \$2,400.00 to be paid in at least \$200.00 increments monthly until total balance is paid in full.

**PAYMENT AGREEMENT**

The following signatures confirm my agreement to pay \$500.00 on \_\_\_\_\_ date. Further, I agree to a monthly payment of \$ \_\_\_\_\_, prescribed in accordance with the information above.

*We accept cash, checks or VISA/MasterCard. If you wish to pay by credit card, simply fill out the information below and this card will be put on file in our system to which all payments will be processed. If paying with a check, please make all checks payable to Branches Counseling Center.*

**Name on Card:** \_\_\_\_\_

**Credit / Debit Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **CVV:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

*If your Billing Address is different than your Home Address, please indicate that on page 3 of the application.*

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Branches Representative Signature**

\_\_\_\_\_  
**Date**

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**CANCELLATION / CHECK RETURN**

Please be advised that there is a \$500 non-refundable deposit to secure your spot in the Intensive. This deposit is due 4 weeks prior to the intensive start date. Should you decide to not come during your original scheduled time, that deposit IS NOT transferrable to another Intensive date.

There is a \$20.00 fee for checks that are returned due to non-sufficient funds.

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

\_\_\_\_\_  
**Client 1 Signature** | *if individual*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client 2 Signature** | *if couple*

\_\_\_\_\_  
**Date**



**Please keep the following pages for your records**



## WHAT TO EXPECT AT YOUR INTENSIVE

*Please keep these last pages of the application for your own records.*

*This schedule will differ based on each individual client's needs. Your schedule may include the following:*

**Individual counseling:** Each person will be assigned an individual counselor with whom they will meet every day. Individual sessions will be based on a collaborative relationship between you and the counselor aimed to bring about a better quality of life. This is a time for you to discuss the issues you want to talk about.

**Chapel:** Chapel is a time to reflect on what God is doing in the counseling process and to listen to Him to know what the next steps are.

**Discipleship training:** Discipleship training is a way to learn biblical disciplines, like prayer and daily Bible reading, to help you learn how to depend more fully on the Holy Spirit and to listen to Him. Learning to incorporate these biblical disciplines when you leave Branches will allow you to grow in your relationship with God.

**EMDR:** EMDR stands for Eye Movement Desensitization and Reprocessing and has been shown to be an effective treatment with individuals who have experienced trauma. It focuses on enabling individuals to heal from the symptoms and emotional distress of these experiences in a shorter amount of time by reprocessing the memory and activating the natural healing processes in the brain. This will only be suggested as part of your treatment plan at the discretion of an EMDR trained counselor.

**Psycho-Educational groups:** These groups are based on learning about specific mental health topics. This knowledge allows individuals to gain a better understanding and therefore enhance their quality of life.

**Support groups:** Support groups are based on a specific topic that everyone in the group can relate to. These groups are facilitated by a counselor.

**Celebrate Recovery:** CR is a biblically-based recovery group that meets off-site to help those struggling with "hurts, habits, and hang-ups." Directions will be provided, and meetings are generally available near your hometown as well.

**Homework:** Occasionally there will be homework assignments to do in your hotel room that are assigned by your individual counselor or one of the group counselors. This homework is to help you continue to learn more about the issues you are facing and the work you are doing in sessions.

**Friday workshop:** The Friday workshop includes wrapping up with individual counselor and creating an exit plan. The exit plan is an individualized plan you create with the guide of one of the counselors that will give you a solid plan for the future.

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## **WHAT TO BRING**

- Bible
- Journal or notebook (*for note taking*)
- Writing Utensils
- Markers (*These will be needed on Monday.*)
- Snacks and drinks (*You will have access to our kitchen throughout the day – for scheduled breaks & lunch.*)
- Layers (*some rooms get hot, some get cold*)
- Water Bottle

## **OVERNIGHT OPTIONS**

*The following overnight options **are not** affiliated with Branches – you are welcome to explore any overnight options such as Airbnb or other hotels while in Murfreesboro, Tennessee for the week of your Intensive.*

**Comfort INN & Suites** (615)869-0950  
226 N. Thompson Lane  
Murfreesboro, TN. 37129

**Hilton Garden Inn** (615) 225-2345  
1335 Conference Center Blvd.  
Murfreesboro, TN. 37129

**Candlewood Suites** (615) 617-3075  
850 N. Thompson Lane  
Murfreesboro, TN. 37129