Adult _____

Tidewater Pastoral Counseling Services, INC.

Client Name _____ / / M F
Last First Middle DOB

Client Address _____ _____
Street City State Zip SS#

Client Phone Contacts _____
Home Work Cell

Client E-Mail Address _____ S M D W
Marital Status

Client Employer _____
Name of Company Occupation

Spouse's Name _____ / /
Last First Middle DOB

Spouse's Address _____ _____
Street City State Zip SS#

Spouse's Phone Contacts _____
Home Work Cell

Spouse's Employer _____
Name of Company Occupation

OTHER FAMILY MEMBERS IN CLIENT'S HOME

_____ / /
Name DOB Relationship

_____ / /
Name DOB Relationship

_____ / /
Name DOB Relationship

Emergency Contact: Name _____ Phone#: _____

Who referred you to TPCS?
Name_____ Relationship _____
(i.e. clergy, insurance company, friend, website, brochure)

Denominational preference _____ Personal Physician _____
Date of last physical _____ Currently under Physicians care? Y N
Have you had any prior counseling Y N When: _____
Are you presently taking any medication? Y N
If so, please list names of all medications? _____

INSURANCE INFORMATION (skip this section if insurance does not apply)

Name of Insurance _____ Identification # _____
Policy Holder _____ Policy Holder's DOB _____

Secondary Insurance _____ Identification # _____
Policy Holder _____ Policy Holder DOB _____

Are any of your sessions authorized as EAP visits through your employer? Yes or No
If so, please provide the authorization number _____ and number of visits authorized _____

CONFIDENTIALITY

Our primary role as pastoral counselors is to create a climate and a relationship that is most conductive for you to enrich your life and your relationships through personal growth. It is, therefore, imperative that you have confidence that your life story will be treated with respect, and that the information you choose to share will be held in strict confidence.

All members of our staff are ministers, who function as representatives of the faith community. The information you share, therefore has a confessional quality. In our function as minister, we retain the right not to release information even with a client's permission.

We will also take whatever steps deemed necessary to protect people from physical or mental harm.

FINIANCIAL POLICY

Our fee for services rendered is $125.00 for the initial visit. Subsequent visits are charged as follows: $120.00 **per** counseling hour (45-50 minutes), $60.00 per half-hour (25 minutes), and $50.00 for group session (90 minutes). **Payment is required when service is rendered.** Only in this manner can we keep our fees to a minimum. If this poses a financial burden to you, you are encouraged to negotiate a method of payment with your counselor. No one will be denied service for inability to pay.

Unless cancellations are made **24 hours prior to your scheduled appointments**, the counselor has the authority to charge you a $55.00 fee. Group fees are charged regardless of attendance**.**

Please read each statement carefully and initial next to each one.

_____ I understand that TPCS retains the right to not release information even with my permission.

_____ I understand that payment is required when services are rendered.

_____ I understand the late cancellation/ rescheduling policy that allows my counselor to charge me $55 for each session missed without 24 hours in notice.

TPCS AUTHORIZATION FOR ELECTRONIC COMMUNICATION

- ☐ I authorize the staff of TPCS to communicate with me via email in all manners of business concerning my care at TPCS.
- ☐ I authorize the staff of TPCS to send me text or email appointment reminders.
- ☐ I am interested in having a debit or credit card on file

Signature: _____

For Clinician Use Only:			
Counselor:	_____	Date:	____/____/____
Diagnosis Code: (ie 309.28)	_____	Referred by:	_____
Agreed Upon Fee	_____		