Because Of Grace™
Consulting & Training Services
"Helping Others Achieve Their Goals & Be Their Best"

Healing of the Soul Ministry
Receiver's Personal Data Form

This information is especially important for our records to help us serve you better. Please answer as completely as possible. Thank You!

Date: ________________________

Full Name ____

Male / Female (DOB) _____________ Age _________

Home Phone_________________________ Work Phone ___________________________

Cell Phone ________________________________

Address ____

City _______________________________________ State___________________Zip ________
Please check where we may leave a voice message: Home _____Work _____ Cell ____Text____

E-mail address:
1)____@_______________________.____________

2) ____ @_____________________.______________

Occupation__________________________Employer Name__________________________

Marital Status: Single ___ In a Relationship ___Married ___Separated ___ Divorced ____ Widowed _____

EMERGENCY CONTACT INFORMATION:
Please list the name and telephone number or email address of two people who can be contacted on your behalf.
Name _____________________________________Telephone # _______________________
Email_________________________________@_________________________.__________ Name
_____________________________________Telephone # _______________________
Email_________________________________@_________________________.__________

Church Involvement: Yes___No__ Member____ Attendee___ Occasional Visitor_____

Pastor's Name_____________________ Church Name & Location______________________________

Ministry Involvement (Church and other)____

Contact Information
757 454-6393 (office)
1251 Kempsville Road Norfolk, Virginia 23502
Email: info@becauseofgracects.com Website: becauseofgracects.com

BECAUSE OF GRACE™
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HEALTH INFORMATION

Rate your health (check): Very Good __________ Good __________ Fair __________ Declining __________

Your approximate weight __________ lbs. Weight changes recently: Lost __Gained ___ Intentional Y / N

List all significant present or past illnesses or injuries or handicaps:
____

Last Physical Exam Date: _____________ Doctor's Report: Excellent___ Average__Fair__Poor_ Declining__

Are you currently taking medication? Yes ___ No ___ Treatment for? _________________________________
Have you used drugs for other than medical purposes? Yes ___ No__ When?____________ What? ______________
Females: Have you ever terminated a pregnancy? Yes __ No __ Have you ever had a miscarriage? Yes ___ No ___
Males: Have you ever been involved in a pregnancy termination? Yes____________ No_________________

MARRIAGE/PREMARITAL AND FAMILY INFORMATION

Have you ever separated? Yes _____ No _____ When? ______________ From ________ to _____________
Has either of you ever filed for or been divorced? Yes ______ No ______ When? ____________
Age when married: Husband _________ Wife ___________ Length of Marriage
How long did you know your spouse before marriage? ____________________
Length of steady dating with spouse _________________ Length of engagement ___________
Give brief information about any previous marriages: (age of marriage, years married)
____
Information about children:

*PM	Name (Print first and last name)	Age	Sex	Living Y N	Live at home Y / N	Marital Status

**Check this column if child is by previous marriage or relationship.*

If you were reared by anyone other than your own parents, briefly explain:
____

How many siblings? _________older brothers _________________ older sisters ________________
younger brothers ________________ younger sisters _______________ Are you Older/Middle/Younger Child

I solemnly swear that the above information is true to the best of my knowledge.

____ __________________________
Signature **Date**

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HEALING OF THE SOUL
CONFIDENTIALITY AGREEMENT

This is to inform you of your right to confidentiality as well explaining the limits of confidentiality. All information disclosed during counseling sessions will remain confidential between you and your counseling minister (s) unless:

The limits to confidentiality are as follows:

- ☐ *Report of neglect, sexual or physical or emotional abuse of a minor.*
- ☐ *Report of neglect, sexual or physical or emotional abuse of the elderly.*
- ☐ *Plan to harm yourself or to commit suicide.*
- ☐ *Plan or knowledge of a homicidal plan.*
- ☐ *Release of Information (permission given by you to share information with a specific person (s)*
- ☐ *Telephone or Internet Counseling*
- ☐ *BOGCTS Intercessors*

I agree to the limits of confidentiality as explained to me and understand that anything that I share with others outside of my counseling sessions is my choice. However, my counselor will not share any information regarding me without my written or verbal permission or under the conditions noted above.

____

Counselee Signature Date

____

Counseling Minister's Signature Date

FINANCIAL CONSENT STATEMENT

Fees for Healing of the Soul Ministry are due before each session via the following Payment Options:

- Make checks or money orders payable to: BOGCTS Mail to: 1251 Kempsville Road Norfolk VA 23502

Other Payment Options:

- Venmo @Rozcaldstan
- PayPal.me/RozBOG,
- Cash App $RosalindStanley
- or call 757 454-6393 to process by phone.

Fees is $115 per session (each session is 2-2 ½ hours)
Appointment cancellation fee applies when not cancelled within 24 hrs of scheduled appointment.

I have read, understand, and agree to the financial information as stated above and take responsibility to pay the fee for HOSM before the session (for myself, spouse, or my family, my minor, or the person I have agreed to cover).

______________________________________ ______________

Client's Initial **Date**

Contact Information
757 454-6393 (office)
1251 Kempsville Road Norfolk Virginia 23502
Email: info@becauseofgracects.com Website: becauseofgracects.com

HEALING OF THE SOUL MINISTRY (HOSM)
RECEIVER AGREEMENT

I, (please print your name) ____,agree to

participate in the HOSM process with (HOSM Minister name) _____________________________________, understanding that the information that I share with my HOSM Minister is confidential.
I understand:

- the limits of confidentiality that they have shared with me
- and accept that though they may be, my HOSM Minister is not necessarily a Professionally Trained Counselor, Ordained Minister, or Pastoral Counselor and is not licensed by any state as such.
- that they have received the required training and have been certified to conduct HOSM sessions.
- and I am also aware of the fee for this service and agree to pay BOGCTS according to the arrangements that we have made.
- and agree to participate in the process of Bible-based prayer counseling ministry that HOSM consists of including necessary homework assignments, with an expectation for explanation or clarification when necessary.
- I understand that HOSM is a process of 5-7 sessions (each lasting 2-2 ½ hours)
- and that I may at times experience painful memories and emotions, but that these memories and emotions are a part of the process of addressing inner wounds or trauma and as a part of working through HOSM.
- that even though I am not guaranteed , I can anticipate emotional/spiritual healing, renewal of my mind, and deliverance as well as a possibility of receiving solutions to the issues that arise or are presented.
- I agree to a follow-up HOSM session a month after my final HOSM session
- and understand that further counseling (1hour sessions) may be requested by me or recommended by my HOSM Minister.
- I agree to complete all sessions of HOSM, understanding the spiritual implications (as noted in Luke 11:25, 26)
- However, understanding that I have the right to terminate this agreement at any time
- If I decide to terminate before completion of HOSM I agree to inform my HOSM Minister or their supervisor in advance, also agreeing to a termination session as this may be in my best interest spiritually and emotionally.

My signature connotes my understanding and agreement to my participation in HOSM with my assigned counseling minister:

____ ____________________

Signature Date

Our goal at BOGCTS is to provide the best pastoral care, concern, and counseling as possible, however if you have a complaint about this HOSM Minister, Step#1: we are willing to discuss the matter with you to bring resolve. Please feel free to contact the BOGCTS Counseling Director at 757 454-6393 or hosm@becauseofgracects.com. If you determine that your complaint requires an investigation beyond step #1, to file a written complaint, you must make it within 90 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it **roz@becauseofgracects.com** or the **BOGCTS address** noted below and: **American Association of Christian Therapists |P.O. Box 3634| Brookhaven, MS| 39603-7634**