CHRISTIAN COUNSELING MINISTRIES
OF WESTERN NEW YORK, INC.
9070 Main Street
Clarence, New York 14031
Phone 716.632.3200 • Fax 716.632.3233
CCMWNY.ORG

To the Clients of Christian Counseling Ministries,

Thank you for choosing Christian Counseling Ministries of Western New York. My goal, as Executive Director of this ministry, is to provide counseling services to individuals and families in need and to ensure the quality of these services. It is important to me that you are satisfied with the help you receive.

All of the therapists on staff are mental health professionals who have graduate degrees from accredited colleges & universities. Each counselor is a committed Christian, is active in a local church, and is equipped to integrate Biblical truth into the counseling process. A copy of our Doctrinal Statement is available on our website as well as a list of the counselors, their degrees, and the institutions they attended.

The counselors receive an agreed upon payment for the counseling they provide to you, irrespective of your fee. If you cannot afford the regular session fee we can adjust it based upon our sliding fee scale. This adjusted fee is based on your gross annual family income and the number of dependents in your family. Family income includes: income from all sources including your employment, spouse employment, parental contributions, child support, social services, etc. Your fee will be adjusted in either direction if income or family size changes. Please inform your counselor if such a change occurs so that we can make the proper adjustment.

It is important that payment be rendered at the time of your appointment. This helps to keep our costs down, eliminates the need for lengthy billing procedures, and keeps our records more accurate. Additional appointments may not be scheduled by your counselor if financial accounts are not kept current.

Please not that this ministry is a non-profit, charitable organization and is able to receive tax-deductible gifts and donations. We are also able to receive United Way donations through its Donor Option Choice Program. Please check with your counselor or our Office Manager on how you can give to our ministry through this program.

I hope you find the services you receive are more than satisfactory. If we can minister to you more effectively, please do not hesitate to let me know. Thank you.

Sincerely in Him,

Dr. Timothy P. Chambers
Executive Director

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INFORMED CONSENT

Welcome, and thank you for choosing **Christian Counseling Ministries of Western New York, Inc.** to help you through the difficult challenges in your life. We encourage you to read the following outlining of policies and procedures of our agency. Your counselor and our office staff are available to answer any questions that may arise.

APPOINTMENTS

Sessions are generally 50 minutes long, and the fee for each individual session is $110. However, we do offer a sliding scale fee based on income and number of dependents to make counseling more affordable. Some of our services may be reimbursable under your insurance provider's out-of-network benefits; we recommend that you check with your provider to see if that is the case for your situation.

Initial _____

CONSENT FOR MINORS

When a counselor sees a minor, parents/guardian are expected to give consent for treatment of anyone under the age of 16. If parents are divorced, it is important for them to follow the custody agreement in regard to who must consent for medical or psychological treatment of the child. If a person other than a parent/guardian is seeking counseling for a minor, he/she must show written legal authority to consent for treatment.

If a minor is being seen in treatment, the counselor may give that child a right to confidentiality, according to the best interests of that minor. The counselor will, however, inform a parent/guardian if the child is at-risk of harm to self or others. It is best to discuss with your counselor how confidentiality for a child will be handled. The counselor's assessment of the best interests of the child will prevail.

Initial _____

CONFIDENTIALITY

It is very important to us that you feel safe in counseling and that you share openly. Any information that you reveal to your counselor, including test results, notes, and records are confidential and will not be released to any outside source without your written authorization. However, there are exceptions to confidentiality which include:

(1) Our legal obligation to protect a client who is at imminent risk of harm to self or others.
(2) Our legal obligation to report suspected abuse or neglect of minors, elderly persons, or disabled persons.
(3) Our legal obligation to comply with a court order in the case of a subpoena, or to comply with any other requests made by a judge.
(4) All of our counselors receive supervision on a regular basis, for professional accountability, and your case may be reviewed. Your actual paper records are the property of CCM and may be reviewed by a director or supervisor for the purposes of professional review and compliance.

During your treatment, the counselor may deem it beneficial or necessary to speak with an outside party (such as a physician, psychiatrist, attorney, etc.) about your treatment. If this occurs, your counselor will ask you to sign a "**Release of Information**" form, giving him/her permission to speak with the stated party for the purposes of treatment and case management.

In the case of marital or family counseling involving adults, it is important to discuss with the counselor how confidential information will be shared between parties. The counselor may elect to have everyone involved sign a "**Shared Information**" agreement to allow all parties to share information and retain a collective, rather than individual confidentiality agreement.

Initial _____

CANCELLATIONS –

We require a 48-hour notice (2 days) if you need to cancel or reschedule an appointment. If that advanced notice is not given, you will be charged a missed session fee which is 50% of your regular session fee. That fee will be due at the time of your next scheduled appointment, or it can be charged to the credit card we have on file. We do understand that there may be emergency reasons for missing appointments and will, therefore, allow you one excused absence after which it will be necessary for us to charge for the hour your counselor has reserved for you.

If you are using a third party, such as an insurance company or church, it is important that you realize they do not reimburse for missed appointments, therefore, you will be responsible for your missed session fee.

If there is a pattern of missed appointments, the counselor or agency director may require you to pay full session fees for late appointments or make pre-payments for sessions before scheduling another visit.

Initial _____

WRITTEN REPORTS

Sometimes it is necessary in the course of treatment for your counselor to provide a progress report, referral, update, extensive insurance information, or other needed correspondence to an outside party. Standard brief reports are part of your payment for services. However, if extensive assessment or paperwork is requested, you will be billed at the rate of $20.00 per page to compensate for the staff's time.

PLEASE NOTE that it is not our policy to serve as a witness or advocate in court proceedings, however, if we need to prepare documents for any court proceedings, reasonable fees will be assessed.

Initial _____

COMMUNICATION OUTSIDE OF CCM

It is most beneficial to you if communication between you and your counselor takes place during the scheduled appointments. However, each of our counselors has a confidential voicemail where you can choose to leave a direct message. If an extensive phone conversation becomes necessary, you will be billed a pro-rated fee for every 10-minute segment past the first ten minutes. You will be responsible to pay for that consultation at your next scheduled appointment.

In addition, any time required for contact with an attorney, physician or psychiatrist that is not initiated by the counselor may be billed to you on the same fee basis as stated above.

If you and/or your counselor decide to communicate via email please note the following - email is not completely secure or confidential. Email should not be used as a substitute for face-to-face counseling, and should be used minimally. You should also be aware that any emails we receive from you, and any responses that we send to you, become a part of your legal record.

Initial _____

CRISIS/EMERGENCY SITUATIONS

It is important to note that counselors are not on-call outside of their scheduled appointments. **We do not provide 24-hour crisis services.** Therefore if you have an emergency, and the office is closed, you should contact:

Crisis Services at (716) 834-3131
Erie County Medical Center – (716) 898-3465
BryLin Hospital – (716) 886-8200 ext. 2264

Initial _____

SATISFACTION

It is our goal to provide you with satisfactory services. If, for any reason, you are not completely satisfied with your counselor, your counseling, or the manner in which you have been treated, please let someone on the staff know of your concerns if you are unable to reconcile those concerns with your counselor.

COUNSELING CONTRACT & CONSENT

I acknowledge that I have received, read, understand, and accept the above policies and procedures outlined in the "Informed Consent". I understand that I am free to, at any time, ask questions or discuss these terms with my counselor. I hereby give my voluntary consent for treatment.

CLIENT SIGNATURE_____ **DATE** _____

CLIENT SIGNATURE_____ **DATE** _____

CLIENT SIGNATURE_____ **DATE** _____

I hereby give the counselor or agency staff permission to contact me and leave messages for me at the following numbers:

Circle one:				Phone Number	Initials
HOME	WORK	CELL	OTHER:	_____	_____
HOME	WORK	CELL	OTHER:	_____	_____

I hereby give the counselor or agency staff permission to correspond with me via mail at the following address:

_____ _____ _____ _____

Street Address *City* *State* *Zip Code*

CREDIT CARD AUTHORIZATION FORM

Please indicate how you would like to use your debit/credit card:

_____ I would like to put my card on file to pay for each session

_____I am planning to pay by cash or check, but would like to put my card on file to be used only in the event that I delay payment by 10 or more days from the date of service, acquire a missed session fee (less then 48 hours notice) or for use on an emergency basis with my expressed verbal consent.

Card Holder's Name (If different from above): _____

Billing Address: _____ _____ _____ _____

Street City State Zip

Debit/Credit Card Type (Please circle one): *Discover* *MasterCard* *Visa* *American Express* *HSA/FSA*

Debit/Credit Card Number: _____Exp. Date: _____ /_____

Security Code: (3 to 4 digit number on the back of your card) _____

I authorize Christian Counseling Ministries of Western New York, Inc. to charge the debit or credit card listed above in accordance with the terms of the cancellation and fee policies agreement found in the consent form.

Card Holder's Signature: _____ Date: _____

Client may cancel this authorization at any time by providing rescission of authorization to use credit card in writing. No other form of rescission will be accepted or be considered valid. Client agrees that prior to any rescission of the credit card authorization, Christian Counseling Ministries of Western New York, Inc. may ensure the client's balance due, if any, is satisfied by the credit card listed above, unless some other form of payment is made.

Counselor's Signature: _____ Date: _____

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EMERGENCY CONTACT RELEASE

I hereby give permission to Christian Counseling Ministries of Western New York to contact the following persons in the event of an emergency:

NAME: _____ **NAME:** _____

ADDRESS: _____ **ADDRESS:** _____

_____ _____

PHONE: _____ **PHONE:** _____

RELATIONSHIP: _____ **RELATIONSHIP:** _____

MEDICAL PHYSICIAN **NAME:** _____

ADDRESS: _____

_____

PHONE: _____

By signing this form, I am not relinquishing my rights of confidentiality concerning the counseling subject matter.

CLIENT NAME(S): _____ _____

ADDRESS: _____

_____ **PHONE:** _____

_____ _____
Signature of Client **Date**

_____ _____
Signature of Client **Date**

_____ _____
Signature of Witness/Counselor **Date**