ASSOCIATION COUNSELING CENTER
INFORMATION SHEET

The Association Counseling Center exists to provide counseling from a Christian perspective for individuals, couples, families and groups. The Center's services are available to all residents of the community regardless of race or religious affiliation.

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. My counselor, Vickie George, will use a variety of interventions in my treatment that would best fit my needs. These interventions have been shown to have validity in one way or another due to research on their methodology and outcome. If you have any questions, Vickie will be happy to discuss them with you. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below.

CONFIDENTIALITY:

Your counselor will carefully maintain your right to confidentiality except in cases of possible harm to self or others, especially children or the elderly, or a criminal court subpoena, or if you plan to use your insurance benefits to assist in paying for your sessions and your insurance company contacts your therapist regarding a treatment plan.

COUNSELING FEES:

The normal fee for a 45minute session is $190.

We ask that your account be kept current and payment be made by check or cash at each counseling session. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. Should counseling be terminated all outstanding fees must be paid in full upon termination.

Please make checks payable to: ***Association Counseling Center, Inc. – Vickie George***

CANCELLATION OF APPOINTMENTS:

If you must cancel your appointment, please phone your counselor at least **48** hours in advance of your scheduled appointment. A charge of the regular fee will be made for the time reserved when cancellations are received *less* than 48 hours in advance. Your cooperation in this regard will be greatly appreciated.

TELEPHONE CALLS:

Should you need to contact Vickie, when calling, please give ***your name***, and your ***telephone number***. Vickie will return your call as soon as she is able. Telephone calls beyond five (5) minutes will be charged at the rate of $190 for 45 minutes.

Your counselor is:

Vickie George, MEd, MS, LMFT, LPC, CST

*Date*_____

Client Signature _____

COUNSELING AGREEMENT
Association Counseling Center

At the Association Counseling Center, the counseling process generally consists of the following phases: assessment, intervention, and termination. The assessment process usually takes one or more sessions. The purpose of assessment is to enable your counselor to get to know you, to understand your problems and concerns, and to establish goals for your counseling.

Once goals are clearly identified, the intervention phase focuses on helping you deal with the problems you are facing, to achieve personal growth, resolve problems. or to make decisions. Depending on the nature of the issues with which you are dealing, the intervention phase may be quite brief or extended over a substantial period of time.

The termination process normally involves a review of the original goals, evaluation of progress, and recommendations for any further steps which may need to be taken. Counseling may be terminated by the client or by the counselor at anytime. The counselor may deem therapy as no longer helpful and will terminate counseling and/or give additional resources.

Effective counseling requires the use of the combined resources of the client and the counselor working together. As an indication of your willingness to participate in this process, you are requested to sign the following agreement:

1. I understand that my counselor is a Masters Level therapist licensed in the State of Georgia as a Licensed Marriage and Family Therapist and a Licensed Professional Counselor. My counselor may seek consultation with another therapist at times if my counselor deems it "clinically necessary".
2. I will pay the sum of $190 per session for my counseling.
3. I understand my confidentiality is maintained except in cases of possible harm to self or others, especially children and the elderly, involvement in a criminal trial, or if my insurance is used and requires more information for payment to me as a client.
4. I understand my counselor is not responsible for any problems with insurance if used, and it is my sole responsibility to deal with my insurance company. I understand that in using my insurance my therapist will be giving me a diagnostic classification as required for insurance reimbursement. I understand that this diagnosis becomes a part of my permanent record. In some instances, it may hinder me from being able to obtain life or disability insurance.
5. I understand that I will pay my counselors hourly rate if her expertise is needed in any legal proceedings of which I am involved. This rate is substantially higher than her normal rate.
6. I understand that touch as a therapeutic tool may be used in my counseling with the sole intent of therapeutic intervention. Therefore, I give informed consent to use touch in the therapy session as may be therapeutically beneficial.
7. I understand and agree to adhere to the policies as stated in the information sheet and further understand that no results are guaranteed.

I understand that cancellation of an appointment requires *48 hours advance notification* and that I will be charged my regular fee for late cancellations.

DATE_____ CLIENT SIGNATURE _____