

CROSSROADS

COUNSELING AND CONSULTATION Consent Form

In what way may the counselor assist you? _____

Have you been in counseling previously? _____ When? _____ How long? _____

By whom? _____

Whom may we thank for referring you to us? _____ Phone: (____) ____ - _____

Have you discussed your counseling needs with your doctor or pastor? Yes No

Would it be helpful if we contacted your doctor or pastor, etc.? _____

If "yes", please provide the information below:

Name	Phone Number	Specify if Doctor, Pastor, or other

I will be paying today by: (*circle one*) Cash Check Credit Card

I have received and read the Statement of Confidentiality and Fee Policy statements.

I consent to and authorize Crossroads Counseling and Consultation to provide counseling services.

Client Signature

Date

Client Signature

Date

Parent or Guardian Signature for Minor child/children or party Responsible for Payment

Date