COMPASSIONATE COUNSELING SERVICES
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 C.C.S.? _____ 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

Whom may we contact in case of emergency? _____ Phone: (___) ___-_____

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 Compassionate Counseling Services to provide counseling services.

_____ _____
Client Printed Name Date

_____ _____
Client Signature Date

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