2219 West Danby Road Spencer, NY. 14883
607.269.7171

www.journeyofhopecounselingcenter.com
journeyofhopecounselingcenter@gmail.com

Patient Demographic Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Cell phone:**
Gender:	**Text ok for session reminders? Y N**
Email Address:	**Allergies:**
Primary Physician:	**Marital Status:**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	

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Informed Consent

Our mission at Journey of Hope Counseling Center is to provide professional, caring, and competent counseling services from a Bible-based and Christ-centered framework. We offer mental health counseling, marriage, family and addiction services that are centered on an unwavering foundation of biblical principles.

Please note, Journey of Hope Counseling Center does not presume that all clients want or will be receptive to explicitly spiritual interventions from a biblical perspective. It is our full and unwavering intention to honor each client's volition and choice in what type of counseling they receive. If you do not wish to have counseling from a biblical, faith-based, and Christ-centered perspective, we would be happy to refer to another practitioner. At Journey of Hope Counseling Center, we provide Christ-centered, bible-based interventions including Scripture reading and reference which we utilize as a roadmap to answer the question "How then shall we live?".

I, _____, want and consent to have Biblical and Christ-centered interventions incorporated into my counseling experience. This may include prayer, reference of Scripture, and encouragement of your faith.

Signature:_____
Date:_____

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Confidentiality Policy

When entering into a counseling relationship, a client should have an assurance that their private information that is discussed during a session does not become communicated to other individuals or parties.

Therefore, Journey of Hope Counseling Center upholds very strict confidentiality requirements at all times. Please note however, there are limitations to this policy which are listed below:

- If an individual is at risk of harm to self or others.
- If there is a report or suspicion of abuse/neglect of a minor.
- A signed consent to release information form will need to be signed by the client for anybody for whom they wish information to be shared.
- Client information may be shared between Journey of Hope Counseling Center staff persons for the purposes of clinical consultation, scheduling, billing and/or bookkeeping. These individuals have a duty to uphold the aforementioned confidentiality policies.

Thank you for taking the time to familiarize yourself with the confidentiality policy. Please let us know if you have any questions.

Signature: _____ Date:_____

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Consent to Release Information

I (client name)_____hereby consent to have my information released in a reciprocal fashion from (Journey of Hope Counseling Center) -or- _____ to (receiver of information)_____.

This consent to release information applies to:

- Update on progress in counseling
- Information about scheduling and/or billing
- Other_____.

This consent is valid for one year from the date of signature on this form and can be revoked at any time.

Signature (Client): _____ Date: _____