Client Contract and Professional Disclosure Statement

Chad Houchin, MA, Psy.D.

Qualifications and Experience:
I am pleased you have selected me for a counseling assessment. This document is designed to inform you of my credentials and philosophy of counseling and to ensure that you understand our professional relationship.

I am a licensed Clinical Psychologist in the state of Virginia. I have a Master's Degree in Philosophy, Theology and Ethics from Biola University, a Master's Degree in Clinical Psychology from George Fox University, and a Bachelor's in Psychology from Colorado State University.

Counseling Philosophy
It is important that you understand from the outset of our counseling that Wellspring Christian Counseling, LLC is a non-profit Christian counseling center established to encourage, equip, and empower people in our community to discover and apply grace-centered living in a way that can bring healing, life transformation and authentic soul change in ways that will enable deeper and more loving relationships with God and each other.

The counseling environment is a safe place to work through life problems and receive objective insight to help make positive life change. I provide counseling that is rooted in Biblical truth while utilizing sound therapeutic techniques. My approach is generally classified as Solution Focused and Cognitive Behavioral, however, I will use God's Word, homework, expressive therapy techniques, and other exercises as I walk alongside you to help you find renewed strength, hope and confidence to face life circumstances.

Areas of Competence and Services Offered
I provide assessment, individual counseling, pre-marital, and select marital counseling. I work with adults, adolescents and children (I do assessment only for children). My clinical interests include anxiety, depression, adjustment disorders, relational conflict, work stress, bipolar disorder, children and families of divorce, parenting, grief, loss, life adjustment challenges, and boundary issues.

Confidentiality
All information we share will be kept confidential with the following exceptions: a) If I believe you are a danger of injuring yourself or someone else; b) If you give me written permission to disclose information; c) In the case of abuse of a child, spouse or an elderly person.

Handling of Emergencies
If you wish to reach me between sessions, please email me at wellspringchad@gmail.com. If there is a mental health emergency, please call 911 or go to the nearest emergency room.

Court Appearances
I do not provide court testimony in divorce cases or child custody cases or any court hearing unless I am subpoenaed by a judge.

Consent to Treatment
By your signature below, you are indicating that you agree to receive a mental health diagnostic assessment and counseling services, and that you authorize me to provide such services as I consider necessary and advisable. You also acknowledge that you have read and understood this statement and have sought clarification of anything unclear to you. By my signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

Payment for office visits is due at the time the service is rendered. There is a service fee for returned checks. There is a $3 processing fee for credit card payments.

If you must reschedule or cancel an appointment, we require at least 24 business hours' notice. There will be a $40 late cancellation fee if notice is not given.

Responsible Party Signature:

Initial evaluation	$150.00
45-60 min. session	$100.00
30 min. session	$65.00
Psychological Testing and Evaluation Comprehensive Battery	$850
Other	$_____

I, hereby, agree that I will be responsible for all counseling related fees. I agree to accept full financial responsibility for services rendered by Wellspring Christian Counseling, LLC. I agree to abide by the conditions outlined in this policy statement and by my signature acknowledge receipt of a copy of this policy.

_____
Client's Signature (If Applicable) Date

_____ _____
Client's/Guardian's Signature (If Applicable) Date

_____ _____
Counselor's Signature Date
Chad Houchin, MA, Psy.D.