Sallie Lowman, LMFT
Licensed Marriage and Family Therapist AL#321
205.613.3282 shlowman@bellsouth.net

COUNSELING SERVICES AGREEMENT

Counselor
As a Christian, and a licensed Marriage and Family Therapist, I utilize Cognitive Behavioral Therapy, forms of Systems Theory, Hope Focused Couple Therapy and Emotion Focused Therapy where these methods are Scripturally congruent. I believe that Spiritual growth is foundational to lasting change, and submit to the authority of Scripture in all matters of faith and practice. I cannot guarantee change in the behavior, or emotional state of those with whom I counsel, nor can I promise client(s) that all problems will be resolved.

Confidentiality & Privacy Policy
The law protects the relationship between client and counselor, and information cannot be disclosed to any other party without written permission.

Exceptions to duty to protect confidentiality include:

- Suspected child abuse, dependent adult or elder abuse. Counselors are required by law to report this to the appropriate authorities immediately.
- A client's threat of serious bodily harm to another person/s, requires counselors to notify police and inform the intended victim.
- A client's threat of self-harm requires counselors to make every effort to enlist that individual's cooperation in ensuring his/her safety. Without an agreement to cooperate, counselors must take further measures without their permission in order to ensure a client's safety.

Counseling Rates An initial evaluation and consultation is $110.00. Subsequent 50 minute sessions are $85.00 due at the time of the session. Extended sessions will be adjusted accordingly. This may be paid by cash, check or credit card. There is a $3.00 processing fee for credit card payments.

Cancellation Policy
Since a regular time slot has been reserved for your appointment, it cannot be offered to anyone else. There will be no charge for cancellation of appointments at least 24 hours in advance. Half fee will be charged for cancellation with less than 24-hour notice. The full fee will be charged for an appointment missed without notification.

Contact Authorization
I authorize Sallie Lowman to contact me and or leave a message at the following phone number:

Home: ___________________ Cell: ___________________ Work: ___________________

I authorize Sallie Lowman to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment, and educational programs during and after the completion of my treatment to my home mailing address or email address.

Yes ______ No ______

I have read the preceding and consent to the above policies.

Date: ________________
Client: _____________________________________ Client: _________________________________
Counselor: ____