



SpringHaven
Counseling Center

CHURCH PARTNERSHIP VOUCHER

VOUCHER #: _____

CHURCH: _____

ADDRESS: _____
Street Address City State Zip Code

PHONE #: _____

DATE: _____

We request payment for services to be divided accordingly:

\$ _____ Church Portion

\$ _____ Client Portion

= \$70.00 (Total fee per session)

We agree to authorize _____ sessions at this time, recognizing that short term therapy usually consists of a minimum of 6-12 sessions.

(Check one):

Yes _____ We will be willing to consider authorization of additional sessions following contact of

_____ at _____
Church Contact Phone #

**Contact Pastor prior to first visit: Yes _____ No _____ N/A _____

**Would like for the counselor to provide you with a brief update of progress if additional sessions are needed? _____ Yes _____ No

No _____ We do not wish to authorize additional sessions. The client may continue under the "Church Partnership Plan" providing they agree to cover the full fee of \$70 per session.

Authorized signatures:

Church Contact Person

SpringHaven Director