SpringHaven
Counseling Center

CHURCH PARTNERSHIP VOUCHER

VOUCHER #: _____ (SpringHaven Office use only) DATE: _____

CHURCH: _____

BILLING ADDRESS: _____
Street Address City State Zip Code

CHURCH PHONE #: _____

We request payment for services to be divided accordingly:

$ _____ Church Portion

$ _____ Client Portion

= $80.00 (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 the contact of:

_____ at _____
Authorized Church Contact Phone #

_____ 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 $80 per session.

Authorized signatures:

_____ _____
Authorized Church Contact SpringHaven Billing Coordinator

Please Fax or mail form to SpringHaven.
Fax # 330.597.9010 Mailing address: P.O. Box 265 Mt. Eaton, OH 44659