2700 South Roan Street, Suite 435 Johnson City, TN 37601 P: 423.408.8041
support@journeycentercounseling.com

The Journey Center for Healing Arts

Contact Agreement

I release all information pertaining to my mental health safety and treatment to my emergency contact person:

_____

Phone #: _____ Relationship:_____

I understand that not all forms of communication are completely confidential, including electronic submission of information through text, email, etc. I understand my confidentiality limits and consent to receive appointment reminders, and communication related to my care, by:

____ Home phone Voicemail Y / N Text Y / N #
_____

____ Mobile phone Voicemail Y / N Text Y / N #
_____

____ Work phone Voicemail Y / N Text Y / N #
_____

___ Email: _____

I have read, I understand, and agree to the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

Printed Name of Client Signature of Client Date

_____

Printed Name of Legal Guardian Signature of Legal Guardian Date

Relationship to client: _____

Client: **Date of Birth:**