CENTER POLICY

Tony Rankin Counseling

D. Tony Rankin MA, LPE
2711 Murfreesboro Road, Suite 100, Antioch, TN 37013
Phone 361.0052 Email address: tonyrankin14@gmail.com

STATEMENT OF TREATMENT

Our purpose is to provide treatment that is appropriate to meet your personal needs and to affect the greatest amount of positive change in the shortest period of time. Our goal is to establish positive, constructive guidance while dealing with specific issues in our clients' lives. Clients may be referred to other facilities or persons for treatment not available at this center.

LEGAL

We are required by law to report all cases of child abuse (physical, emotional, or sexual) to the Children's Protective Services Agency. We are required by law to report all cases of abuse of the elderly, disabled, and/or mentally retarded to the Adult Protective Services Agency. Suicidal clients will be referred for hospitalization and/or medical treatment and a responsible party will be notified. Our counselors will become a part of the legal issues of our clients and will appear in court on behalf of our clients.

FINANCIAL

Our goal is to provide professional, competent service at the lowest possible cost to our clients. Our service fees are posted for your convenience. Fees are due and payable at the time the service is performed.

APPOINTMENTS

Your counselor will suggest the proper program regimen for effective treatment. Scheduling will be done through our business office. It is in the best interest of the client and the counselor to maintain consistency in keeping scheduled appointments. Please notify the business office of your rescheduling needs at least 24 hours prior to your appointment time. Missed appointments without notification will be charged to your account.

DISCLAIMER

I have read and understand this Policy statement. I agree to abide by its stipulations and enter counseling under the conditions stated above. I have voluntarily sought counseling on my own initiative. I reserve the right to accept or reject the counseling given as I deem appropriate. I understand that the counselor(s) involved in my treatment, and the Center itself assumes no responsibility for me personally, for my behavior, mental/emotional well-being, or physical health. (If applicable) I further state that I am the legal guardian of _____, a minor, and have voluntarily sought and consented to counseling for said minor under this Center Policy as stated herein.

CLIENT _____ **DATE**_____

RESPONSIBLE PARTY _____ **DATE**_____

COUNSELOR _____ **DATE**_____