Jerry F. Smith, S.T.D. INDIVIDUAL, MARRIAGE, and FAMILY PSYCHOTHERAPIST and SPIRITUAL GUIDANCE

PASTORAL THERAPY ASSOCIATES 625 Commerce, Suite 400, Tacoma, WA 98402, VOICE MAIL 253-627-1691

RECEIPT OF DISCLOSURE AND CONFESSIONAL ACCORD STATEMENT

I hereby certify that I have read, understood, agreed to, and received a copy of Dr. Smith's Client Information material. His Disclosure Statement has informed me of the mission and policy of Pastoral Therapy Associates and my rights as a client. I am acquainted with the education, training, theological orientation, and professional licensure of Dr. Smith.

All information shared in any form in Dr. Smith's office is part of a clinical ministry context and separate (confessionally and sacramentally) from any other purpose.
I understand that all of my (our) counseling communication (including any information stored or retrieved by any written, oral, or electronic means) is entirely protected, private, and confidential and that it will not be disclosed to anyone outside Dr. Smith's office.

I will not seek, and do not want, to have any disclosure of my personal counseling information outside of Dr. Smith's office. If I need any psychotherapy or spiritual information disclosed in the future, I will obtain it from a different resource. Due to the confessional clinical ministry context of his counseling, I understand that Dr. Smith does not keep healthcare records

I understand what my fee is for counseling and I agree to pay the fee at each counseling session unless other arrangements have been made with Dr. Smith. If I "no show" or fail to cancel an appointment within 48 hours of its scheduled time, I will be responsible to pay the fee for that session.

______________________________	____________________
Client's Signature	Date
______________________________	____________________
Client's Signature	Date
______________________________	____________________
Guardian signature if a minor	Date
______________________________	____________________
Therapist's Signature	Date