Hope & Freedom

COUNSELING SERVICES

Cristina "Tina" Wehner, MTSC, LCMHCS, CHFP, CSAT-S, CPTT-S, CCBRT

21345 Catawba Avenue - Cornelius, NC 28031 - 704-464-0065

Agreement Between Client and Therapist

The following is an agreement entered into between Hope & Freedom Counseling Services, Cristina Wehner (LCMHCS #9221) and _____ as client(s).

Professional Disclosure Statement

Qualifications & Counseling Philosophy: I am a **Licensed Clinical Mental Health Counselor Supervisor** (LCMHCS #9221) and the current **President of Hope & Freedom Counseling Services**, where I have served since 2020. I provide intensive outpatient psychotherapy primarily to individuals and couples.

I hold several advanced professional certifications, including **Certified Hope and Freedom Practitioner** (CHFP) through Hope and Freedom Counseling Services, as well as **Certified Sex Addiction Therapist – Supervisor** (CSAT-S), **Certified Partner Trauma Therapist – Supervisor** (CPTT-S), and **Certified Couples Betrayal Recovery Therapist** (CCBRT)—all through the **International Institute for Trauma and Addiction Professionals** (IITAP).

I earned a **Bachelor of Arts in Human Services** from Elon University (1997) and a **Master of Theological Studies in Counseling** from **Gordon-Conwell Theological Seminary** (2002). I am also a former licensed and ordained minister with the International Church of the Foursquare Gospel, where I served in a variety of ministry roles for over a decade.

My clinical work is centered on the treatment of **trauma- and process-related addictive behaviors**, including sexual addiction, love and relationship addiction, disordered eating, financial compulsivity (such as gambling and shopping), and workaholism. Additional areas of specialization include **trauma and PTSD**, **abuse recovery, anxiety and mood disorders, codependency, life transitions, relational and family dynamics, and support for individuals and families impacted by addiction and personality disorders**.

I am **Level II trained in Eye Movement Desensitization and Reprocessing** (EMDR), with additional training in the **Feeling State Protocol** (FSAP). My therapeutic approach is further informed by 12-Step facilitation therapy, multiple levels of the **Gottman Method** for couples counseling, and externship training in **Emotionally Focused Therapy** (EFT) with Dr. Sue Johnson. I also serve as a **Director with Prepare-Enrich**, offering assessments and therapeutic services to couples seeking premarital or marital support. My clinical training includes over **240 hours of specialized instruction in trauma and addiction recovery**, under the guidance of esteemed professionals such as **Dr. Patrick Carnes** and **Dr. Milton Magness**.

*My approach to psychotherapy is grounded in a deep commitment to serve as a catalyst for meaningful transformation. I strive to empower individuals to live with **authenticity**, **integrity**, **balance**, and **purpose**. I believe healing comes through the holistic integration of **body, mind, soul, and spirit**—fostering lasting **peace**, **resilience**, and **wholeness** from the inside out.*

Clients' Initials ➔➔➔_____ /_____

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Information and Privacy Practices - Informed Consent

Please Initial Each Section Below

_____/_____ **Nature of Outpatient Psychotherapy:** I utilize an integrative therapeutic approach, drawing from a variety of evidence-based modalities, including psychodynamic therapy, cognitive-behavioral therapy (CBT), solution-focused therapy, task-centered therapy, and experiential therapy. This flexibility allows me to tailor the therapeutic process to each client's unique needs, goals, and lived experience.

While my clinical work is informed by a biblical worldview and guided by values of compassion, integrity, and restoration, therapy is not faith-dependent. I welcome and respect clients from all religious and non-religious backgrounds, and there is no expectation that clients share my personal beliefs. I am committed to providing a safe, respectful, and nonjudgmental space where your values are honored and your well-being is the priority. For those who desire it, I am equipped to incorporate Christian counseling into the therapeutic process. With formal theological training and years of experience in ministry, I bring both clinical and spiritual sensitivity to clients seeking faith-integrated care.

_____/_____ **The Therapeutic Relationship and Process:** Therapy is a collaborative process that depends on your active engagement both during and between sessions. To support your growth and healing, you may be given therapeutic exercises, journaling prompts, or reflection activities to complete outside of sessions. These are designed to help you explore new perspectives, strengthen emotional insight, and develop healthier patterns of behavior.

We will regularly evaluate your progress together and make adjustments to the treatment plan as needed to support your ongoing emotional and mental well-being. Session frequency is determined collaboratively based on your clinical needs, goals, and the nature of the work we are doing. While I provide guidance, structure, and clinical expertise, your openness, honesty, and willingness to engage in the process are key to creating meaningful and lasting change.

To make the most of each session, please bring a journal or notebook. The use of electronic note-taking devices during sessions requires my prior approval, as outlined in the Photographs, Session Recordings & Electronic Devices section of this agreement.

Outside of scheduled appointments, client-therapist communication is limited. As a matter of professional ethics and healthy boundaries, Hope & Freedom Counseling Services does not accept gifts of significant value.

_____/_____ **The Risks and Benefits of Therapy:** As with any psychological treatment, therapy involves both potential benefits and inherent risks. Over the course of our work together, you may encounter a range of emotions—such as sadness, anxiety, anger, or frustration—as difficult or unresolved issues are explored. It is also possible to experience temporary disruptions in relationships, daily routines, or behavioral patterns, or to recall distressing memories. These reactions, while sometimes uncomfortable, are a normal part of the therapeutic process and often signal that meaningful work is taking place.

Therapy also offers significant potential benefits. Clients often report improvements in mood, relationships, communication, and overall well-being. Therapy can help clarify values and goals, enhance coping strategies, increase self-awareness, and reduce emotional distress or symptoms that may have prompted treatment. While I am here to offer guidance, insight, and support, your consistent engagement and willingness to participate actively in the therapeutic process are essential for lasting change and healing.

Should our therapeutic relationship come to an end—whether due to treatment completion, referral, or another reason—we will typically discuss the transition in advance and collaboratively explore appropriate next steps. Referrals to other qualified providers can be offered upon request or as clinically indicated. However, it is ultimately your responsibility to secure any continued care you may need. Neither the therapist nor Hope & Freedom Counseling Services is liable for your care following termination unless otherwise agreed upon in writing.

_____/_____ **Disclosure of Deceptive and Acting Out Behaviors:** In cases involving behavioral or sexual addiction recovery, we may explore the potential therapeutic value of disclosing past deceptive, compulsive, or problematic behaviors to your partner. Disclosure, when done thoughtfully and with clinical support, can play a vital role in rebuilding trust, fostering accountability, and promoting relational healing.

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As part of this process, I will guide you through the emotional, relational, and psychological implications of disclosure. This includes discussing timing, format, and the possible use of a polygraph examination as a verification tool. While disclosure can initially increase relational stress or emotional distress—and in some cases may even contribute to the end of a relationship—it is often a meaningful and necessary step toward long-term recovery and integrity. The decision to disclose is always your own. My role is to support you in making an informed and intentional choice that aligns with your recovery goals, values, and the needs of your relationship.

_____/_____ **Client Rights and Responsibilities:** Each client's therapeutic journey is unique. Some individuals may achieve their goals within a few sessions, while others may benefit from a longer-term therapeutic process. Session frequency may evolve over time based on clinical need and progress—ranging from weekly meetings to bi-weekly, monthly, or periodic check-ins. You are free to discontinue therapy at any time; however, I strongly encourage scheduling a final session to support a healthy and intentional conclusion to our work together. You have the right to decline or request a modification to any therapeutic intervention that you feel may be unhelpful, ineffective, or uncomfortable. Clients are expected to arrive for sessions free from the influence of alcohol or non-prescribed substances, as these impair the effectiveness and safety of the therapeutic process.

If at any point you have concerns about your care or feel you have been treated unethically, I encourage you to bring those concerns to me directly. Open dialogue is a vital part of the therapeutic relationship, and I welcome opportunities to address any issues that may arise. If a resolution cannot be reached, you have the right to file a formal complaint with the North Carolina Board of Licensed Clinical Mental Health Counselors at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417; lpcinfo@ncblcmhc.org; 844-622-3572; fax: 336-217-9450.

_____/_____ **Referrals:** If, at any point during the course of treatment, I determine that your needs would be better served by another provider or require services outside the scope of my practice, I will offer appropriate referrals. This may include referrals to medical professionals, psychiatrists, or specialized treatment programs. In some cases, a higher level of care—such as intensive outpatient, inpatient, or residential treatment—may be recommended to ensure your safety or to provide the appropriate clinical support for your needs. While I am glad to assist in identifying potential resources, it is ultimately your responsibility to initiate contact, assess fit, and pursue the recommended services. I do not prescribe medication but can provide a referral to a qualified medical provider upon request.

_____/_____ **Email and Texting:** Clients may choose to communicate with me via email or text message for administrative purposes such as scheduling, appointment reminders, or clarification of assigned exercises. By initiating contact through these means, you are providing implied consent for me to respond in kind. However, please be aware that electronic communications are not secure and may be vulnerable to unauthorized access by third parties. Clients are expected to use discretion when sharing any private or sensitive information via electronic communication, and Hope & Freedom Counseling Services is not responsible for any breaches of confidentiality that may occur through these platforms.

Email and text should not be used for personal disclosures, clinical concerns, or session-related content. These matters are best addressed within the context of a scheduled therapy session, where privacy, nuance, and clinical support can be appropriately provided. If a message includes therapeutic content or indicates a need for support beyond administrative coordination, I reserve the right to suggest that you schedule a session to discuss the matter more thoroughly. You may revoke permission to communicate electronically at any time by submitting a signed written request.

_____/_____ **Social Media and Technology Policy:** To maintain appropriate professional boundaries and protect the integrity of the therapeutic relationship, I do not engage with clients on personal social media platforms such as Facebook, Instagram, Twitter, or similar channels. Connecting through social media may compromise confidentiality, blur therapeutic roles, and impact the objectivity essential to effective treatment. I also do not communicate with clients through messaging apps (such as WhatsApp, Signal, or social media DMs), nor do I interact on personal blogs, comment threads, or public online forums.

All communication will be conducted through approved professional channels, such as phone, secure email (for administrative matters), or any designated client portal. If you come across my profile on a professional directory or review site, please know that I will not respond to public comments or ratings in order to protect your privacy and uphold ethical standards. In the event that an incidental or unintentional connection is made on any digital platform, I reserve the right to remove or disconnect it without notice, in order to mitigate the boundary violation and preserve the integrity of the therapeutic relationship. This policy is designed to safeguard

your confidentiality, ensure clarity in our communication, and maintain the clinical effectiveness of our work together.

_____/_____ **Other Clinical Personnel and Support Providers:** At times, other licensed therapists, interns, or clinical support staff may be present at Hope & Freedom Counseling Services for purposes of co-therapy, supervision, training, or program support. These professionals are bound by the same ethical, legal, and confidentiality standards as your primary therapist. If a therapist or intern is directly involved in your care—for example, through co-therapy or observation—you will be informed and your written consent will be required before any access to your clinical records or participation in your sessions. However, you may encounter interns or support staff onsite who are not involved in your treatment. In these cases, your privacy remains protected, and your clinical information is never shared without your explicit permission.

Therapy Fees and Payment Terms

_____/_____ **In Person Intensive Therapy Rates:** The fee for a Three-Day Intensive Therapy Program is $7,500, which includes 18 hours of direct therapeutic services. Any additional hours beyond the included 18 will be billed at the standard hourly rate. One-Day Aftercare Intensives are offered at a rate of $2,500, and Half-Day Aftercare Intensives are available for $1,250. A complimentary screening phone call is required prior to scheduling, along with submission of the appropriate application(s). Intensive programs are scheduled only after receipt of a nonrefundable and nontransferable deposit equal to one-half of the total therapy fee ($3,750). The remaining balance is due on the first day of the scheduled Intensive.

If an Intensive is cancelled within seven (7) days of the scheduled date, the client may request to reschedule; however, the original deposit will be forfeited, and a new nonrefundable deposit must be paid in order to secure a future date. If a client or couple chooses to discontinue treatment during an Intensive, the full fee remains nonrefundable and the program will be concluded. Please carefully review your schedule and commitments before booking an Intensive, as availability is limited and programming is arranged in advance. Requests for non-traditional scheduling (such as holidays, Sundays, or acute crisis accommodations) may be submitted but are not guaranteed. If approved, an additional fee of $750 per day will apply. Housing, meals, and transportation are not included and are the responsibility of the client(s).

_____/_____ **In Person Traditional Individual and Couples Appointments:** The initial assessment session for individuals is approximately 90 minutes and is billed at $625. For couples, the initial assessment is a 3-hour session with a fee of $1,250. This fee includes pre-session assessments completed online, a comprehensive review of results, and covers new client administrative costs. Standard ongoing individual therapy sessions are approximately 60 minutes in length and billed at $415 per session. Ongoing couple sessions are approximately 90 minutes and billed at $625 per session. These rates apply to all session formats, including in-person, phone, or video appointments.

_____/_____ **Virtual (Zoom/Phone) Telehealth Appointments:** Hope & Freedom Counseling Services offers brief, solution-focused virtual therapy appointments for individuals seeking targeted therapeutic support, recovery guidance, and ongoing progress monitoring. Standard appointments are approximately 45 minutes in length and billed at $300 per session. When clinically appropriate, shorter appointments may be available, including 30-minute focused check-ins at $200 and 15-minute brief consultations at $100. These appointments are designed to address specific treatment goals, reinforce recovery skills, and provide focused therapeutic interventions. Appointment duration and availability are determined by the therapist based on individual clinical needs. These services do not replace comprehensive assessments or Intensive Therapy Programs when more extensive treatment is indicated. All other standard therapy rates remain unchanged.

Payments are due at the time services are rendered and may be made by electronic funds transfer (EFT), cash, check, or credit card. Electronic transfers by bank are preferred. Please refer to the Payment Policy for information regarding additional fees that may apply when using a credit card.

Other Fees

_____/_____ **On-Site Guest Accommodations:** On-site guest accommodations are available at a rate of $200 per night, with an additional $100 cleaning fee per visit. This fee covers cleaning services, linens, towels, basic supplies, and light breakfast or snack items. Dietary restrictions may be communicated in advance, but accommodations are not guaranteed. Amenities may include a hair dryer, basic toiletries, tea/coffee makers, washer and dryer access, a fully equipped kitchen, free parking, and Wi-Fi; however, these

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amenities are offered as a courtesy and are not guaranteed. Guest accommodations are considered an external service and are not associated with the cost of therapy. These fees will be billed separately and are entirely optional.

_____/_____ **Administrative Fees:** There is a $250 flat-rate charge for each letter requested by or on behalf of a client. If additional documentation, preparation, or mailing is required beyond the initial letter, an administrative fee of $50 per half hour will apply. These fees cover the time and resources involved in preparing materials not included in standard therapeutic care.

_____/_____ **Legal Requests:** If the therapist is required to appear in court or provide testimony, there is a flat rate of $2,500 per day. This minimum fee applies regardless of the duration of testimony or appearance. If the therapist is required to be present in court for additional days (e.g., awaiting testimony), each day is charged at the same $2,500 rate. Travel time is billed at the same rate, except for appearances within Charlotte city limits, for which there is no travel charge. For out-of-town travel (defined as more than 50 miles from downtown Charlotte), a minimum of one-half day ($1,250) is charged for travel to the court location, and one-half day ($1,250) is charged for return travel. All travel-related expenses, including hotel, meals, and transportation, are the responsibility of the client and are billed separately from the daily appearance fee.

_____/_____ **Unpaid Balances and Returned Checks:** Payment is due at the time services are rendered. Unpaid balances may be referred to a collections agency, and any associated collection fees will be added to the client's bill. A $50 fee will be assessed for any returned checks due to insufficient funds or other banking issues.

_____/_____ **Polygraph Examinations:** Polygraph exams are available at a cost of $750, paid directly to the examiner. Polygraph services are provided by independent professionals and are not affiliated with Hope & Freedom Counseling Services. These services are considered private, optional, and initiated at the request of the client.

_____/_____ **Therapist Approved Discounted Provisions:** Hope & Freedom Counseling Services does not offer a formal sliding scale. However, session discounts may be considered on a case-by-case basis when requested and approved in advance. Any discounted rate will be discussed prior to the start of treatment, documented in writing below, and must be approved by Tina Wehner, as indicated by her initials. All discounted rates are granted at the sole discretion of the therapist and may be withdrawn at any time. In the event that a discount is discontinued, you have the right to continue treatment at the full contractual rate or to terminate services without penalty.

Therapists' Initials Required ➔➔➔_____

_____/_____ **Emergency Services:** Hope & Freedom Counseling Services does not provide emergency or crisis services. If you are experiencing a medical or psychological emergency, please go to the nearest hospital emergency room or call 911. For local clients, you may also contact the Carolinas Medical Center Crisis Hotline at (704) 444-2400. Therapy services provided through this office are by scheduled appointment only and are not a substitute for emergency psychiatric care.

_____/_____ **Consideration of Others:** To help maintain a peaceful and respectful environment for all clients, we ask that you be mindful when visiting the office. Please refrain from wearing strong fragrances, keep conversations quiet in shared spaces, and observe our electronic device policy during therapy sessions. These small courtesies help preserve the therapeutic atmosphere and comfort of everyone in the space.

_____/_____ **Cancellation, Late, and Missed Appointment Policy:** Cancellations for individual, couples, family psychotherapy, and telephone sessions require at least 24 hours' advance notice for standard hourly appointments (1 to 3 hours), and a minimum of two weeks' notice for Intensive Appointments (half-day or longer) in order to avoid being charged for the missed session. This cancellation policy does not apply to group psychotherapy. Clients enrolled in group sessions are billed for all scheduled groups, whether or not they attend—including absences due to vacations or other personal scheduling conflicts.

Exceptions to the cancellation policy are considered only in cases of dire emergencies such as hospitalization, serious accidents, or the death of a family member. Such exceptions are handled on an individual basis. Charges for missed or late-cancelled appointments will be applied to the client's account or the credit card on file. If you arrive late to your session, it will still end at the originally scheduled

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time to honor the time of other clients. If your session begins late due to a delay on the part of the therapist, you will receive the full session time or your fee will be adjusted and pro-rated accordingly.

_____/_____ **Records and Confidentiality:** All client communications become part of your clinical record, which is the property of Hope & Freedom Counseling Services and is protected under North Carolina law. Confidentiality is strictly maintained, except in circumstances where disclosure is legally required. These include situations involving risk of harm to self or others; suspected abuse or neglect of a child, elderly, or disabled person; disclosure of sexual contact with a mental health provider; a court order mandating disclosure; a client-authorized release of records; or any other disclosure required by law.

If we encounter one another in public, I will not initiate contact in order to protect your privacy. You are welcome to acknowledge me if you choose, and I will follow your lead. Administrative staff may have limited access to client information for scheduling and billing purposes only. In cases involving multiple clients—such as couples—written consent from all participating individuals is required before any protected health information can be released.

_____/_____ **Protection of Your Confidential Records:** If a subpoena for your clinical records is received, my legal team will take appropriate steps to protect your confidentiality, including filing a motion to quash when warranted. By initialing this agreement, you indicate your understanding and consent to cover any legal fees incurred in the process of protecting your records. If court attendance becomes necessary to further safeguard your information, you agree to assume responsibility for all associated legal and professional fees, as outlined in the legal services section of this document.

_____/_____ **Couples and Family Counseling – No Secrets Policy:** In the context of couple or family therapy, I maintain a general commitment to honoring individual disclosures made in private. However, I also adhere to a "no secrets" policy when such information is likely to negatively impact the therapeutic process, compromise the safety of others, or undermine the integrity of the work. While I encourage open and honest communication among all participants, I reserve the right to determine when information shared individually must be addressed within the group setting in order to support transparency and clinical progress. In cases where significant or harmful information is withheld, I may determine that continued treatment is no longer appropriate and may recommend termination of services or referral to another provider.

_____/_____ **Photographs, Session Recordings, and Electronic Devices:** A photograph of client(s) may be taken and securely stored in the clinical file for therapist reference. With your informed consent, sessions may be audio or video recorded for the purposes of treatment planning, clinical review, or documentation. Any recordings made by the therapist will be handled with strict confidentiality and stored in accordance with HIPAA and ethical guidelines.

To protect the privacy and integrity of the therapeutic process, clients and other participants are not permitted to record, transcribe, photograph, livestream, or otherwise electronically capture any portion of a therapy session without my prior express permission. This policy applies to both in-person and virtual sessions and includes the use of phones, smart watches, smart glasses, tablets, computers, artificial intelligence (AI) applications, transcription services, AI note-taking programs, voice assistants, screen recording, or any other technology capable of listening to, recording, transcribing, summarizing, transmitting, or storing information discussed during a session.

During in-person sessions, personal electronic devices capable of recording or capturing session content must be left outside the therapy room or placed in a designated location unless I have approved their use for a specific therapeutic purpose. If you need access to your phone or another device for an important personal, medical, or accessibility-related reason, please discuss this with me in advance.

There may be occasions when recording a specific therapeutic exercise, instruction, or educational segment is beneficial to your treatment. In such cases, you must request and receive my express permission before beginning any recording. When other clients or participants are present, their express consent is also required. Permission to record a specific portion of a session does not extend to the remainder of that session or to future sessions. Any permitted recording must be used only for the agreed-upon purpose and may not be shared, distributed, or uploaded to third-party platforms without appropriate authorization.

Covert, undisclosed, or background recording, transcription, AI listening, or other electronic capture of therapy sessions is not permitted. If I become aware of or reasonably believe that unauthorized recording or electronic capture is occurring, I reserve the right

to pause or end the session until the matter is resolved. Intentional violation of this policy may result in a review of whether continued treatment is appropriate and, when clinically indicated, referral to another provider.

This policy is designed to safeguard the confidentiality of all participants, maintain appropriate professional boundaries, and preserve the safety and effectiveness of our therapeutic work together.

_____/_____ **Acknowledgment and Consent:** By signing below, you acknowledge that you have read and fully understood the information presented in this informed consent document. You affirm that you have had the opportunity to ask questions and have received satisfactory answers. Your signature indicates your voluntary agreement to the terms, policies, and conditions outlined above, and your commitment to participate in therapy in good faith.

(Each participant is required to review and sign this agreement prior to the start of services.)

_____	_____	_____
Client Signature	Date	Printed Name
_____	_____	_____
Client Signature	Date	Printed Name
_____	_____	
Therapist's Signature	Date	

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Client Payment Agreement & Credit Card Policy

Payment for services is due at the time of your session and may be made by cash, electronic check, electronic funds transfer (EFT), or credit card. However, all clients are required to have either bank account information or a credit card securely stored on file in order to confirm and guarantee scheduled appointments. This ensures that any late cancellations or no-shows (as outlined in the cancellation policy above) can be promptly billed. In such cases, charges will be processed automatically, and an electronic receipt will be issued. This policy exists to honor the value of our mutual time and to support the consistency and professionalism of the therapeutic process.

When deposits are required for future services, such as Intensive Therapy programs, this agreement also serves as your written consent to process advanced charges with your verbal approval. An itemized electronic receipt will be provided for any such charges.

Electronic funds transfers are preferred, as they do not incur additional processing fees. Please note that a processing fee of up to 3.5% may be applied to credit card transactions to cover merchant service costs. This fee will be disclosed at the time of payment. No additional fees are applied to payments made via EFT, cash, check, or debit card. Refunds will incur two fees, administrative fees for time ($5/min)and electronic merchant reimbursement fees (2%).

We reserve the right to charge clients in accordance with this policy. Your payment information is protected under HIPAA and securely stored within your file or encrypted within our billing system (e.g., QuickBooks). By signing this agreement, you acknowledge and consent that all charges or debits against your account must comply with applicable United States law.

Client Payment Information:

Client Name(s): _____

Electronic Funds Transfer or E-Check

Name of Bank/Financial Institution: _____

Account Holder Name: _____

Routing Number: _____ Check Number: _____

Account Number: _____ Checking Account ____ Savings Account ____

Credit Card Information

Type of card: □Visa □Master Card □AMEX □ Other: _____

Name on Card: _____ (Relation to Client): _____

Card Number: _____ Expiration Date: _____

3/4 Digit Code: _____ Billing Zip Code: _____

*Client Signature _____

*Signature denotes permission to process payments which include Electronic Funds Transfers and/or credit card charges/fees.

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