

## **INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES**

*Around the Corner Counselling Ltd.*

### **BENEFITS & RISKS**

Psychotherapy may involve both benefits and risks. **Risks** may include: uncomfortable feelings, the sense that things are getting worse before they get better, and in certain cases (i.e., group therapy, therapeutic filmmaking, third parties, etc.) the risk of loss of privacy. There may also be risks that are unknown at this time. However, there are also known benefits. **Benefits** may include: reduced distress, increased satisfaction in life and relationships, greater personal awareness and insight, increased coping skills, and resolutions to specific problems. There are also risks to not seeking treatment for mental health issues, such as the problem getting worse with greater impact on your functioning.

### **APPOINTMENTS**

Unless otherwise specified, appointments are typically 50 minutes long. **Cancellation Policy:** If you cancel without 24 hours' notice or fail to show up to an appointment, you will be charged the regular fee for the missed session. Please note that insurance and EAP companies typically do not cover the cost of missed appointments, so clients will be directly responsible for missed session fees.

**I understand and agree to the cancellation policy:    Y    N**

**I agree to be charged for the cost of a missed session on the following credit card:**

**Credit Card Number:** \_\_\_\_\_  
**Expiration Date:** \_\_\_\_\_ **CV2 Number:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

### **PROFESSIONAL FEES**

I charge **\$200 per 50-minute session** unless otherwise specified. Payments may be made by credit card, cash, personal cheque, e-transfer, or cashier's cheque. If a cheque bounces, I require the client to pay my bank's service fee for bouncing the cheque (\$35), in addition to the cost of the session. Payments may be made at the time of the session or as indicated on an invoice. If payment is not received in the specified time, I may use a Collections Agency to obtain payment. If you anticipate becoming involved in a **court case**, you may be required to pay for the professional time required of me even if another party compels me to testify.

### **PROFESSIONAL RECORDS**

I keep professional records in a secure, confidential manner. These records include information on attendance, reasons for therapy, the goals and progress in treatment, topics discussed, your medical, social, and treatment history, records I receive from other providers, and copies of records I send to others. You own your own information and I protect it as private and confidential. Except in unusual circumstances that involve a danger to yourself or others, or where copyrighted testing material must be protected, or where a third party owns your file, you have the right to a copy of your records.

**CONFIDENTIALITY**

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent. However, there are some important exceptions to this rule.

Limits to confidentiality include:

- My duty to protect vulnerable persons (dependent adults and minors)
- Self-regulation (I must report misconduct by other psychologists)
- Court proceedings (files/testimony may be subpoenaed for use in court)
- Imminent risk (I must report specific, immediate threats to self/others)
- Records of minors (parents cannot be denied access to a minor client’s file)

**PARENTS & MINORS**

It is my policy not to provide treatment to a child under age 14 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless I feel there is a safety concern.

**CONTACTING ME**

Please feel free to connect with me via phone, e-mail, or text, though these forms of communication cannot be guaranteed confidential. If you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please do one of the following: **1) go to the nearest Hospital Emergency Room; 2) call the Distress Line at 780-482-4357, or, 3) call the Mobile Crisis Response Team at (780) 342-7777.** As a rule, I do not accept requests for connection through **social media** from current or past clients.

**CONSENT TO PSYCHOTHERAPY**

Your signature below indicates that you have read this Informed Consent form and agree to receive psychological services under these terms. This consent is considered valid for one calendar year from the date indicated below.

\_\_\_\_\_  
Signature of Client/Representative

\_\_\_\_\_  
Signature of Client/Representative

\_\_\_\_\_  
Printed Name of Client/Representative

\_\_\_\_\_  
Printed Name of Client/Representative

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Client Information Form**

Name(s): \_\_\_\_\_  
Date(s) of Birth: \_\_\_\_\_ M F Or Preference: \_\_\_\_\_  
Phone Number 1: \_\_\_\_\_ Message? Y N  
Phone Number 2: \_\_\_\_\_ Message? Y N  
E-mail Address: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_

**Please describe the issues you are here to see me about.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you seen a therapist/counsellor/psychologist in the past? Please explain.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever been diagnosed with a mental health issue?**

\_\_\_ In the past, but not now (please specify diagnosis/date: \_\_\_\_\_)  
\_\_\_ Yes, currently (please specify diagnosis: \_\_\_\_\_)  
\_\_\_ No, never

**Please describe medications currently taken and any relevant medical history.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Payment Information**

Insurance [ ] Company: \_\_\_\_\_

FNIHB [ ] Contact: \_\_\_\_\_

Policy/Case/Treaty #: \_\_\_\_\_

**\*\*\*\* FOR OFFICE USE ONLY \*\*\*\***

Rate per hour: \_\_\_\_\_ Private [ ] Insurance [ ] EAP [ ]  
[ ] Consent explained and signed [ ] Cancellation policy reviewed  
Parental Consent For Child Received From: Mother [ ] Father [ ] Other: \_\_\_\_\_