



*Welcome to Insight Psychological!*

*At Insight we have compassionate, fully experienced and highly qualified professionals offering a wide variety of counselling services for many issues. Working together with your psychologist/counsellor, you will be able to identify goals for counselling and to evaluate your progress towards these goals.*

## **CONSENT FOR TREATMENT**

I, \_\_\_\_\_ hereby consent to receiving psychological treatment with the following understandings:

### **Confidentiality**

I understand that all information shared with my therapist is confidential and no information will be released without my written authorization. I understand that any personal information that is collected is done so under the Health Professions Act, the Personal Information Protection Act (PIPA) and the Freedom of Information and Privacy Act (FOIP) and is gathered by Insight Psychological Inc. solely for the purposes of collecting fees, mailing forms, and arranging appointments. This information will not be released to other third parties or used for any other purpose than those outlined within this document.

Verbal consent for limited release of information may be necessary in special circumstances which will be discussed and attained prior to any action taken with my personal information. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, my therapist is ethically and legally bound to take necessary steps to prevent such danger. This may include contacting relevant authorities even if I do not wish my therapist to do so.
- B. When there is a reasonable suspicion that a child, elder, or any vulnerable person is being sexually, physically or emotionally/psychologically abused, neglected, or is at risk of such abuse, my therapist is legally required to take steps to protect the person and to inform the proper authorities.
- C. All other requests for my personal information to be either released or obtained by my therapist or other professionals (e.g., my family physician, lawyers, etc.) will be discussed as they arise and will require my written permission to comply, unless ordered by court.
- D. In case I have elected to see my therapist out of multiple offices, I understand that this requires the physical transfer of my file, which may jeopardize my confidentiality (i.e. in the case of a vehicle collision or theft).
- E. That non face to face work (i.e. phone, Skype etc.) has certain confidentiality risks associated with it as Insight cannot control the client's technology access or privacy limitations. Please also see Skype privacy statement put out by Microsoft.

### **Therapy agreement**

I understand that I am eligible to receive evidence-based treatment in the form of individual/group/family therapy. The type and extent of service that I will receive will be collaboratively determined thorough discussion with me.

I understand that I am free to discontinue these services at any time without penalty or prejudice (with the exception of late cancellations/no shows as identified below) and that I am encouraged to discuss either a change in therapist, approach, or a referral to another professional with my therapist to ensure that I receive the best care possible.

I understand that this consent will remain in effect until such a time as I withdraw it via written consent or discontinue services with my therapist by informing them of my intent to do so.

### **Attendance**

Individual therapy sessions are between 50 and 60 minutes in duration. Session frequency can vary over the treatment period, depending on the specific therapy goal and the progression of treatment.

I agree to inform my therapist at least 24 hours prior to our appointment time if I need to cancel or change an appointment time. I understand that **unexcused no shows or cancellations with less than 24-hour notice will be automatically billed/charged at 50% of the total cost of the session booked.**

**Financial agreement**

I understand and accept that my session fee is \$200 per one hour for face-to-face, online, and telephone therapy/consultation session (which entails 50 to 55 minutes of meeting time and 5 to 10 minutes of report writing time for each session but excludes initial telephone, in-take, or scheduling time). I also understand and accept that other billable services, such as report writing, professional letters, form completion, and review of written records from other specialists are billed at the same rate unless made known to me otherwise. I understand that a retainer amount may be collected to hold an appointment or prepare for an assessment and that additional charges will be added to that retainer to reach previously discussed or agreed upon fee for service and fees shall not exceed the agreed upon amount.

I agree to pay promptly at each face-to-face, online, and telephone therapy/consultation session, all fees and charges owed to Insight Psychological, except for the amounts that can be immediately received or that have already been approved for payment by a third party through instant direct billing by Insight Psychological or through a pre-established contractual agreement. Insight Psychological accepts VISA, MASTERCARD, debit or cash for services rendered. I give my consent to Insight Psychological to charge my credit card on file and/or to access other agreed upon means of payment, for the outstanding fees and charges owed to Insight Psychological. Service fees are tax deductible and I will receive a receipt upon payment. I understand that should I be unable to remit full payment for any outstanding fees and charges owed, I will not be able to book and access any further services at/from Insight Psychological until such a time as I have paid my outstanding fees and charges in full. I hereby also agree to pay all fees, charges and legal costs incurred for services associated with the recovery of outstanding amounts owed.

**Risks and benefits**

I understand that while psychotherapy may provide significant benefits based on empirical evidence, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recollection of troubling memories. I also understand that choosing not to engage in therapeutic treatment may also result in greater discomfort or escalating risks. It has been explained to me that my feedback and communication about the therapy process and impact is crucial in reducing my risk for harm, and my therapist has encouraged me to communicate any concerns or discomforts with them as soon as is feasibly possible in my treatment. I also acknowledge that therapy is most effective when I am comfortable with my therapist and so, should I not feel comfortable or connected to this therapist I will either request a transfer to another individual or make my concerns known in order to best facilitate care for myself.

**Rights and responsibilities**

I have a right to be treated with respect, dignity, and without discrimination regardless of my age, gender, mental and physical status, sexual orientation, race, belief system or ethnic background. I can expect my therapist to make their best effort to conduct therapy as competently as possible. I have a right to ask questions at any time, be informed by my therapist as to their qualifications, areas of specializations and limitations, and the code of ethics which they follow. I have a right to be advised as to the limits of therapeutic service, discuss my treatment with others (including getting a second opinion), and have been informed of the College of Alberta Psychologists’ grievance procedures. I understand that I may stop treatment at any time. I understand that I have a right to view my file notes at any time and to know what is being recorded about me.

I understand that I am responsible for setting therapeutic goals for my treatment and review them as required. I will cooperate with my therapist in evaluating the treatment process and work toward achieving my self-identified goals.

Client (please print): \_\_\_\_\_

Witness (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**CLIENT CONTACT INFO:**

NAME: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_