

## INFORMED CONSENT FOR COUNSELLING SERVICES

In signing this consent form, you are agreeing to the terms outlined below. If you require clarification of any point, please discuss it with your Counsellor before signing.

I, \_\_\_\_\_, of \_\_\_\_\_  
(Name) (Address)

Hereby consent to participating in counselling **sessions with Rory Boutilier [Registered Professional Counsellor]** and I understand and agree that:

1. What I say during counselling sessions will be held in strict confidence and will not be divulged to anyone without my express written consent that will include specifics to be discussed. My Counsellor cannot be held responsible for how my information is handled by the third party.

### Exceptions to confidentiality include:

- a. If my Counsellor or clinical file is subpoenaed by the courts or a legal warrant is produced.
  - b. If I am deemed to be at risk of harm to myself or others,
  - c. If there is an imminent or suspected abuse to a child or vulnerable adult. Please speak to your Counsellor for further explanation.
  - d. The Canadian Professional Counsellors Association (CPCA) and/or approved clinical supervisor has the right to audit a candidate Counsellor's files if they perceive a need to **protect the public**.
2. To maintain a level of professional integrity, Counsellors are required to consult with other Counsellors on an ongoing basis. **No identifying information will be shared under these circumstances.**
  3. My Counsellor may use audio recording during sessions; **I will be aware when this happens.** Audio recordings are used by my Counsellor to make notes after the session, rather than taking notes during session. Notes made from recordings may be discussed with my Counsellor's CPCA-approved supervisor for the express purpose of ensuring and maintaining best practices in client care. **These recordings will be treated in the same secure and confidential way as my file and will not be shared for any other purpose.**

### FEES:

The counselling hour typically allows for 55 minutes with the Counsellor and 5 minutes reserved for file review and notations. Fees for this service, as well as for consultations, reports, and letter writing, are \$80.00 per hour. Payment accepted in cash or e-transfer and a receipt is given at the end of each session.

**Please check with your insurance provider regarding coverage.** *Sorry, we do not do direct billing at this time.*

### MISSED APPOINTMENTS OR INSUFFICIENT CANCELLATION NOTICE:

In the case of illness or inclement weather, a telephone session may be arranged at the scheduled time. **To avoid being invoiced for a missed session, we require at least 24 hours' notice of cancellation or reschedule. Short notices will only be in emergency situations (inclement weather, family emergency, etc.). Appointments can be cancelled by phone or email only please. If you arrive late or leave early, you will still be charged for the full session.** Please call if you expect to be late.

I have read, understood, and agree to the terms noted above:

\_\_\_\_\_  
(Client Name)

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Parent/ Guardian Signature)

\_\_\_\_\_  
(Date)

## CLIENT INTAKE FORM

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
 Email: \_\_\_\_\_

Okay to leave a phone message? Yes No      Email? Yes No

Age	Date of Birth	Marital Status	Gender

Occupation: \_\_\_\_\_ Name of Employer /Workplace: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_

Family Physician Name & Contact Info: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

**Counselling Coverage (If Applicable):**

Provider Name Insurance Provider / Other	ID	Contact Information Phone / Address

**Present Household:**

Name Spouse / Child	Age/ Date of Birth	Relationship

**Confidentiality:** As a Registered Professional Counsellor with the Canadian Professional Counsellors Association, I adhere to a strict confidentiality policy. All the information between you and your Counsellor or staff members will not be shared or disclosed to anyone without permission from you. I also adhere to a strict professional Code of Ethics; Exceptions (1) subpoena from a Federal or Provincial Court; (2) criminal code violations where abuse of children, elderly, or vulnerable person(s) is involved; (3) whereby any person's life or health is in obvious danger.

I understand the above:

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

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

Witness: \_\_\_\_\_

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

**PRESENTING PROBLEM:**

What brought you here today?

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**MEDICAL HISTORY**

Tell me about any medical problems you have: chronic illnesses, traumatic injuries, head injuries, major surgeries, chronic pain? Include dates, hospitalization information, and disabilities.

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Medication(s):

Prescription Type	Diagnosis	How Often	How Long

**EMOTIONAL/MENTAL HEALTH**

How would you describe yourself emotionally?

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Have you had any thoughts of hurting yourself or another? Yes\_\_\_ No\_\_\_

Do you have any current suicidal thoughts, and/or intent to end your life? Yes\_\_\_ No\_\_\_

Do you presently or have you in the past had any of the following:

Risk Factor	Yes	No	Comments
Suicidal Thoughts			
Homicidal / Violent Thoughts			
History of Violent Behavior			
Paranoid Thoughts			
Hallucinations			

What significant problems or stresses are you facing at the present time?

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**TREATMENT GOALS**

What would you like to achieve in our work?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Is there anything I did not ask that you thought I would, or anything else you think would be helpful?

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