STEPHANIE KOVACS, PH.D.
REGISTERED PSYCHOLOGIST
4794 JOYCE AVE. POWELL RIVER, BC V8A-3B6
TEL: (604) 414-7654 FAX: (604) 485-2820
WWW.SUNSHINEMENTALHEALTH.COM

MRN:

NOTE: THIS FORM CANNOT BE COMPLETED ELECTRONICALLY. PLEASE PRINT AND SIGN BY HAND.

Patient's Name: (print) ____________________ ____________________
LAST FIRST

CONSENT TO TREATMENT

Description of Psychotherapy:
Psychotherapy addresses issues of the whole person. Therapy may address your biology, thoughts, behaviours, relationship(s), and the meaning or purpose of your life. Most forms of therapy are designed to help people change some aspect of their lives to become more responsible, independent human beings. Good treatment is assessment-driven, which means that you may be requested to complete questionnaires or tests to more effectively guide and monitor your treatment progress.

Procedures:
If you decide to take part in therapy, you are agreeing to therapy-related assessment (if requested), homework assignments, and to engage as a collaborator in effecting the desired changes in your life. If you have questions about any procedure, recommendation, or homework assignments, you are free to ask for an explanation at any time. You may decline to take part in any part of therapy or withdraw at any time.

Risks and Benefits of Therapy:
Many people find the process of change and recommendations toward change difficult. During the process, you may experience some anxiety, guilt, loss, sleeplessness, or a heightened sense of awareness. Therapy can sometimes precipitate some interpersonal conflict. The process of change can be quite difficult with varied results. There are no guarantees that therapy will be effective for any individual. In general, therapy does tend to lead toward greater health and contentment. You are likely to become much more self-aware, self-confident, and self-content. Happier people tend to be happier in their personal, professional, and social relationships.

Confidentiality:
There are legal and practical limits to confidentiality. For example, if your treatment is paid by a third party provider, they may have the right to request confidential material or require progress reports. A court may order disclosure of records. Administrative staff and the regulatory body of psychologists will have access to information on a need-to-know basis. On occasion, Dr. Kovacs may discuss your case with another psychologist colleague as part of routine practice. These individuals agree to keep material confidential, and any identifying information is withheld or disguised as much as possible. Records will be stored for seven years from the age of majority in a secured location as per requirements set under the Health Professionals Act.

Confidentiality will be legally breeched if you or your child:

- Threatens to harm him/herself or is at-risk of incurring serious harm
- Threaten to harm others or engage in reckless behavior that would put others in serious harm
- Disclose neglect, physical, emotional, or sexual abuse of a child, elder, or other vulnerable population
- Has been told not to drive but continues do so (adolescents only)
- Court order

Please note: *If the child has another parent/legal guardian who does not live with yourself and the child, and is not aware of the therapy (e.g., joint custody agreement), he/she must be made aware, and **Dr. Kovacs must have written consent from him/her**, before the treatment may begin. If this applies to your child, please inform Dr. Kovacs so that the appropriate parent/legal guardian may be contacted. Thank you.*

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Consent Statement:

I,______________________ have read/been told and understand the limits of confidentiality, risks and benefits of treatment. This statement certifies the following: that I am the legal guardian of the named patient who is under 19 years of age, that I am 19 years of age or older, that I consent to treatment of the named patient, and all my questions have been answered.

____________________________________ Date: ____/_____/______ __________________________
SIGNATURE OF PARENT / GUARDIAN MM DD YYYY NAME OF CHILD

____________________________________ Date: _____/_____/_____
2ND PARENT / GUARDIAN SIGNATURE (IF APPLICABLE) MM DD YYYY

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FEE AND POLICY AGREEMENT FOR PROVISION OF PSYCHOLOGICAL SERVICES

Patient's Name: (print) ____________________ ________________________
LAST FIRST

FEES

I, (please print)______________________________ agree to contract with Dr. Stephanie Kovacs of Sunshine Mental
FIRST LAST
Health for psychological services on a fee-for-service basis provided at an **hourly rate of $185, consistent with current rates for Registered Psychologists. I understand and agree that the initial visit for assessment or therapy will be billed a one-time fee of $200.**

Patients are responsible for payment of fees at each session or in accordance with the terms listed below. Dr. Kovacs will provide receipts after each session for third party reimbursement. All payment of accounts are ultimately the patient's responsibility.

POLICIES

- **24 hour cancellation policy.** First missed visit billed at half rate.
  All subsequent missed or late-cancels will be billed at full rate. Your insurance may not cover this.
- **Sick –** Please do not come when sick. You will not be penalized. Phone or web sessions are available.
- **Checking In –** Always check in at front desk. Do not use text to announce your arrival.
- **Emergencies –** Dr. Kovacs is not an emergency-responder.
  Appropriate Emergency Resources: 911, hospital, crisis hotline (24/7) 1-800-784-2433.
- **Communication –** Save therapy questions for therapy. Due to volume, Dr. Kovacs is unable to respond to every message but will always try. Missed calls without a voicemail will not be returned.
- **Outside the Office –** To protect your privacy, Dr. Kovacs will always follow your lead if we meet in the community. She will always pretend we have never met unless you decide otherwise. It's best not to discuss your therapy content if we meet in public.
- **Outstanding Payments –** Dr. Kovacs retains the right to charge 1.5% interest compounded monthly on balances outstanding beyond 90 days. By signing below, you understand that if the balance is based on a running account, 1.5% interest will be compounded monthly on the cumulative balance after the first 90 days of this signature. You further acknowledge and approve of Dr. Kovacs sending unpaid balances after 1 year of your last appointment to a collection service.
- **Letters/Forms Rates –** Billed by the hour. 15-30 mins ($92.50)
- **Hardcopy Fees –** 50 cents / page if 25pgs or less. 25 cents / page if >25pgs.

I have read and understand the above fee agreement and policies for provision of psychological services. My signature below indicates that I understand this agreement and hereby agree to the terms and conditions stated herein.

__________________________________ Date: ____/_____/______
SIGNATURE OF PATIENT / GUARDIAN MM DD YYYY

Relationship to patient (if applicable): ___________________________

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CHILD HISTORY

PLEASE PRINT

The information your provide is strictly confidential and will be used only to aid in your care. Exceptions to confidentiality discussed in your first visit also apply to the information on this form. If you feel uncomfortable answering any item, please leave it blank and discuss with Dr. Kovacs.

CHILD INFORMATION

FIRST NAME ____ LAST NAME ____ MI ____

DATE OF BIRTH: MONTH ____ DAY ____ YEAR ____ AGE ____

GENDER: ____ RACE/ETHNICITY ____ BIRTHPLACE ____

PRIMARY ADDRESS

STREET ADDRESS ____ CITY ____ PROV ____ POSTAL ____

EMERGENCY CONTACT:

FIRST NAME: ________________________ LAST NAME: ________________________
HOME PH: ________________________ CELL PH: ________________________ WORK PH: ________________
RELATION TO PATIENT: ______________________________________

PARENT INFORMATION

PARENT #1

FIRST NAME ____ LAST NAME ____ AGE ____ RELATION ____

HOME PH: ____ - ______ - _______ OK TO LEAVE VOICEMAIL? ___Y ___N
CELL PH: ____ - ______ - _______ OK TO LEAVE VOICEMAIL? ___Y ___N TEXT? __Y __N
WORK PH: ____ - ______ - _______ OK TO LEAVE VOICEMAIL? ___Y ___N
EMAIL ADDRESS: ____

EMPLOYMENT STATUS: ☐ FULL-TIME? ☐ PART-TIME? ☐ UNEMPLOYED? ☐ RETIRED?
CURRENT OCCUPATION: ____
COMPANY NAME: ____
#YEARS WITH COMPANY: ___________________
HIGHEST LEVEL OF EDUCATION: ____

PARENT #2

________________________ ___________________________________ _______ ______________________
FIRST NAME LAST NAME AGE RELATION

HOME PH: ____ - ______ - ________ OK TO LEAVE VOICEMAIL? ___Y ___N
CELL PH: ____ - ______ - ________ OK TO LEAVE VOICEMAIL? ___Y ___N TEXT? __Y __N
WORK PH: ____ - ______ - ________ OK TO LEAVE VOICEMAIL? ___Y ___N
EMAIL ADDRESS: ____

EMPLOYMENT STATUS: ☐ FULL-TIME? ☐ PART-TIME? ☐ UNEMPLOYED? ☐ RETIRED?
CURRENT OCCUPATION: ____
COMPANY NAME: ____
#YEARS WITH COMPANY: _____________________
HIGHEST LEVEL OF EDUCATION: ____

FAMILY INFORMATION

PLEASE LIST ANY SIBLINGS, STEP-SIBLINGS, OR HALF-SIBLINGS; THEIR AGE; AND HOUSEHOLD.
Eg., Susan (sister, age 12, same home) Brian (step-brother, age 15, dad's home)

ACADEMIC INFORMATION

_____________________________________ ___________ _______________________________
SCHOOL GRADE TEACHER

DESCRIBE ANY SPECIAL PROGRAMS OR ACCOMMODATIONS YOUR CHILD UTILIZES AT SCHOOL
(EG, IEP, ONLINE CLASSES, HONORS, CMA, ETC.)

DESCRIBE HOW YOUR CHILD IS DOING ACADEMICALLY AND LIST ANY SPECIFIC AREAS OF CONCERN OR HIGH ACHIEVEMENT.

SOCIAL INFORMATION

RELIGION: ____

HOW IMPORTANT IS RELIGION/SPIRITUALITY IN YOUR HOUSEHOLD? ______________________

ANY CURRENT MARITAL STRESS IN THE HOME:

ANY CURRENT FINANCIAL STRESS:

IN GENERAL, HOW WOULD YOU DESCRIBE THE WAY YOUR CHILD GETS ALONG WITH PEOPLE?

HOW MANY CLOSE FRIENDS CAN YOUR CHILD RELY ON? ________

PLEASE DESCRIBE YOUR SOCIAL SUPPORT NETWORK:

DESCRIBE ANY PEER PROBLEMS:

IS YOUR CHILD SEXUALLY ACTIVE THAT YOU KNOW OF? ____ Y ____ N

LIST ANY REGULAR ACTIVITIES OR SPORT WITH WHICH YOUR CHILD IS INVOLVED:

MEDICAL HISTORY

DOCTOR'S NAME:____

CURRENT PRESCRIPTIONS:

PAST PRESCRIPTIONS:

SIGNIFICANT HEALTH HISTORY OR CONDITIONS:

SUBSTANCE USE - **IDENTIFY ANY USAGE YOU ARE AWARE OF FOR YOUR CHILD**

CURRENT:

PAST:

LIST ANY EXPERIENCES WITH DRUG REHAB PROGRAMS OR CURRENT RECOVERY GROUPS:

LEGAL HISTORY

LIST ANY CRIMINAL CHARGES OR OPEN LEGAL DISPUTES:

LIFESTYLE

PLEASE DESCRIBE YOUR CHILD'S CURRENT LEVEL OF PHYSICAL ACTIVITY:

PLEASE DESCRIBE YOUR CHILD'S CURRENT DIET / EATING HABITS:

PLEASE DESCRIBE ANY PROBLEMS WITH YOUR CHILD'S SLEEP:

DEVELOPMENTAL HISTORY

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING PREGNANCY:

CHECK ONE: VAGINAL DELIVERY C-SECTION

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING DELIVERY:

CHILD'S WEIGHT AT BIRTH: ____________

HOW WOULD YOUR DESCRIBE YOUR CHILD'S GENERAL TEMPERAMENT IN INFANCY?

PLEASE IDENTIFY ANY DEVELOPMENTAL DELAYS REGARDING MILESTONES:

PHYSICAL (Eg., sitting, rolling, crawling, walking, toileting, etc.)

COGNITIVE & COMMUNICATION (Eg., speaking, counting, vocabulary, etc.)

SOCIAL & EMOTIONAL (Eg., empathy, making new friends, approaching others, integrating, right vs. wrong, etc.)

PSYCHOLOGICAL HISTORY

PREVIOUS COUNSELLING? (LIST NAMES, DATES, AND THE PRIMARY PROBLEMS):

EG., DR. SUSAN SMITH 2010-2012 DEPRESSION

____

____

PREVIOUS HOSPITALIZATIONS FOR PSYCHIATRIC PROBLEMS?

____

____

PREVIOUS TESTING / ASSESSMENTS?

____

____

FAMILY MENTAL HEALTH HISTORY (*EG, MOTHER (DEPRESSION)*)

MATERNAL SIDE ____

____

PATERNAL SIDE ____

____

HAS YOUR CHILD EVER DISCLOSED THOUGHTS OF SUICIDE OR HURTING HIM/HERSELF? DESCRIBE

DO YOU BELIEVE YOUR CHILD IS CURRENTLY SUICIDAL? IF SO, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY SIGNIFICANT EVENTS THAT YOU BELIEVE HAVE AFFECTED YOUR CHILD:

HAS YOUR CHILD EVER EXPERIENCED A SERIOUS TRAUMA/ABUSE? IF SO, PLEASE EXPLAIN:

TELL ABOUT ANY PROBLEMS WITH DEPRESSION:

TELL ABOUT ANY PROBLEMS WITH ANXIETY:

TELL ABOUT ANY PROBLEMS WITH ANGER/AGGRESSION OR DEFIANCE:

HOW DO YOU EXPLAIN WHAT IS GOING ON IN YOUR LIFE?

WHAT ARE YOUR EXPECTATIONS FOR THERAPY OR ASSESSMENT? WHAT SPECIFIC GOALS WOULD YOU LIKE TO ADVANCE?

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?

____