φ *Pacific Health*
Counselling & Consulting

708 - 1155 West Pender St.
Vancouver, BC
Canada
V6E 2P4
(778) 988 – 9327
wayne@phcounselling.com

INFORMED CONSENT

Scope of Counselling

Counselling provides an opportunity for clients to articulate their concerns, reflect upon their beliefs and values, and explore avenues that will allow them to engage meaningfully within social, occupational and other important areas of their lives. Establishing an authentic therapeutic relationship is considered to be the primary vehicle for effecting change; therefore, the counsellor will work collaboratively with the client in order to obtain therapeutic goals. Please note, within this informed consent form, the term "client" may refer to either an individual or a couple.

Confidentiality

Confidentiality is of paramount importance in a counselling setting. The counsellor will not divulge the client's information, or the content of the sessions, to any other party unless a situation arises in which the counsellor has an ethical, or legal, obligation to breach confidentiality or the client has signed a Release of Information form stipulating what information may be divulged. Situations in which a counsellor may be required to breach confidentiality are outlined in the section below on Limits to Confidentiality.

Limits to Confidentiality

A counsellor may be required to breach confidentiality in the following situations:

A. *If a child or vulnerable adult is at risk of abuse or neglect, and is unable to seek support or assistance, or is in need or protection;*
B. *If a client or another person is at clear risk of imminent harm;*
C. *If the counsellor is required to comply with a court subpoena;*
D. *If the client operates a vehicle while impaired by substances, then the counsellor is required under the Motor Vehicle Act to report the client to the proper authorities.*

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Remuneration

Payment will be made at the start of each session or as agreed to between the counsellor and client. The fee for each counselling session shall be: $_______

Cancellation Policy

Twenty four hours' notice is required in order to cancel or reschedule an appointment. The full fee shall be applied to all appointments cancelled with less than 24 hours' notice. Missed or late appointments shall be charged the full fee.

CONSENT TO COUNSELLING

My signature below confirms that I have read the above, discussed the content with the counsellor, and had all my questions answered to my complete satisfaction. I understand that by signing below I agree to collaborate with the counsellor.

____

Name of Client (Please Print)

__________________________ __________________

Signature of Client ***Date Signed***

__________________________ __________________

Wayne P. De Connick, MA, RCC ***Date Signed***
Clinical Counsellor (#12494)

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INTAKE FORM

*Date:*_______________________ *Referred by:*______________________________

Identifying Information

*Last name:*_____________ *First name:*_____________ *Middle name:*____________

*Preferred name:*_________________

*Date of birth:*_______________ *Age:*_____ *Gender:*____________________

Contact Information

*Tel:*________________ *Alt Tel:*________________ *can we leave a message? Y / N*

*E-Mail:*_____________________

*Address line 1:*____________________________

*Address line 2:*____________________________

Marital Status

- ❑ *Single*
- ❑ *Married*
- ❑ *Common Law*
- ❑ *Separated*
- ❑ *Divorced*
- ❑ *Widowed*

*Partner's name:*_______________________________________

*Partner's date of birth:*_______________ *Age:*_____ *How long together?*_______

Children

*Name:*______________________ *Date of birth:*___________________ *Age:*______

*Name:*______________________ *Date of birth:*___________________ *Age:*______

*Name:*______________________ *Date of birth:*___________________ *Age:*______

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Emergency Contact

*Name:*____

*Tel:*____________________ *Alt Tel:*___________________

*Relationship to you:*_________________________________

Health History

*Family doctor:*____________________________________

*Tel:*_________________ *Fax:*________________

*Significant health issues:*____

____

____

____

____

*Medications:*____

____

____

____

____

*Date of last physical examination:*__________________