

## Harmony Counselling - Treatment Agreement

Please take some time to read the following counselling information and service terms:

This form is to document that I/we give permission to **Lorena Patrucco**, who is a Registered Psychotherapist (qualifying), to provide psychotherapy services to me/us and /or my child/ren

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I understand that the therapist is responsible for all aspects of the psychotherapy services provided to me.

### Information Regarding Counselling:

**Counselling Sessions:** the session is 50 minutes and we can meet in-person weekly, bi weekly, or monthly depending on each unique circumstance or need.

Should your session be provided through an online medium, all the efforts are made to ensure the use of secure and reliable telecommunication compliant with the PIPEDA Act. However, some associated privacy risks may be involved using this therapy format that you agree to assume, despite how safe the medium may be.

**Fees:** payments are due at the time of service and a receipt will be issued at the end of the session. If you arrive part-way through the session, we will counsel you for the remainder of your session time and you will be billed for the entire session.

### Professional Fees:

1. \$\_\_\_\_\_ is the rate charged per clinical hour (50 minutes). This rate also applies on a pro-rated basis for all other professional services, including, but not limited to: report writing, attendance at meetings, consultations with other professionals, resource preparation, and phone conversations of a clinical nature.
2. Payment is to be made at the time of each session, unless otherwise agreed upon. Payments can be made by cash, e-transfer, cheque, or credit card.
3. Interest of 3% per month will be charged on overdue accounts. A fee of \$35.00 will be charged for cheques returned by the bank due to insufficient funds. Non-payment of any substantially overdue account will result in interruption in treatment until the account is paid in full.

### Cancellation:

We understand that with today's busy lifestyles you may need to re-schedule your appointments from time to time. In order to ensure that Harmony Counselling makes the best use of the time and to provide service to as many people as possible, it is **imperative** that you reschedule or cancel your session **at least** 24 hours prior to your schedule time. Please call me at **647-896-2103** for re-scheduling or cancelling an appointment. **You will be charged the full fee for missed sessions.**

### E-mail/Voice Mail:

We will return all e-mails or voice mails within 24 hours.

### **Information about your Rights to Confidentiality:**

It is your right to have the information you disclose remain confidential. Confidentiality is a high priority at our clinical practice. What this means to you as a client is that we will not disclose anything that is discussed within a session with anyone unless you give your verbal consent or written permission (or guardian for those participants under the age of 16). Youth aged 12 years older have the right to seek counselling which will remain confidential from others (including parents and guardians). Exceptions to confidentiality include the legal and/or ethical obligations to:

- There is reasonable belief that you will harm yourself or others.
- There is reasonable belief of neglect, physical or sexual abuse of a minor, including the witnessing of domestic violence.
- The counsellor's file or information is subpoenaed by a court of law.
- To facilitate an investigation or inspection if authorized by warrant or by any provincial or federal law (e.g. a criminal investigation against the Member, his/her staff, or a client).
- For the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally; and
- To a professional college for the purpose of administration or enforcement of the Regulated Health Professions Act, 1991 (e.g. providing information about a client to the College if a complaint has been made against a regulated health professional, assessment of the Member's practice as part of the Quality Assurance Program; mandatory reporting where the Member's client is a regulated health professional and the Member has reasonable grounds to believe that the client has sexually abused a patient/client).

In order to provide you with the best quality services, we will occasionally seek consultation with other colleagues and/or clinical supervision. These consultations allow counsellors to discuss cases and receive suggestions for interventions. The information provided to the supervisor is confidential and names are removed from case descriptions (or aliases will be used).

### **Client Files:**

Your file will be kept for a period of 10 years after your last session or 10 years after a child turns 18 years of age. Files will be destroyed in a safe manner following that period of time.

### **Privacy Policy:**

I understand that to provide me with goods and services, Harmony Counselling will collect some personal information about me (e.g. name, address, telephone, gender, health history, etc.). I have had the opportunity to review the Harmony Counselling Privacy Policy about collection, use and disclosure of personal information and have had an opportunity to ask any questions regarding this policy. I agree to Harmony Counselling collecting, using and disclosing personal information about me as set out in the Harmony Counselling Privacy Policy

### **Custody:**

All parents/guardians authorizing counselling services for their child/ren under the age of 16 must be in their legal right to do so. In any situation of joint, shared, or undetermined custody, it is expected that all parties will provide written consent to counselling. In signing this agreement, I/we declare that I/we are within our legal rights to engage my/our child in counselling, and will notify the counsellor of any changes to legal custody arrangements.

**My signature verifies that I have read and understood the terms discussed above and that I have had the opportunity to discuss these terms with my therapist and have had my questions answered to my satisfaction.**

**Signature of client (aged 12 +):** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Signature of parent/guardian:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Signature of parent/guardian:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

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