Family Counselling Centres

Administrative Office
PO Box 5492
Leduc, AB T9E6L7
T. 780.612.8577
F. 888.601.2991

Counselling/Mental Health
Disclosure and Consent Statement

Clinical and Therapist Information

Our primary commitment is to provide you with quality counselling services. However, no therapist can guarantee that services will be effective for you. This statement is intended to convey pertinent information regarding our services, allowing you to make choices based on correct information.

THERAPEUTIC INTERVENTIONS

There are some risks associated with counselling. As you explore aspects of your life, there may be unpredictable results, which lead to painful memories, and or uncomfortable emotions. A therapist's goal is to provide you with the tools to help manage these emotions. All psychological interventions will be explained to you. Occasionally, a particular intervention might involve the use of physical touch. In such cases, I will always ask permission to use touch.

You have the right to refuse the use of touch as well as any other therapeutic intervention offered during a session.

You also have the right to terminate any intervention that is underway simply by saying "stop."

SCHEDULING, CANCELLATIONS AND MISSED APPOINTMENTS

One clinical hour equals 50 minutes of session time. The remaining 10 minutes of each hour are dedicated to writing client progress notes. Please ensure that you arrive on time for your session. Your 50-minute session begins at the scheduled time. Session times will not be extended to accommodate late arrivals. Longer sessions (90Minutes, or Two-Hours) are available but this *must* be arranged in advance.

Cancellations must be received 24 hours prior to the scheduled appointment. If 24 hours of notice is not given, you will be required to pay THE FULL AMOUNT for the missed session before booking another session. It is best to contact your clinician directly via telephone/voicemail for last-minute appointment changes.

Missed appointments must be paid for *unless* one of the following occurs:

- *You become ill*
- *You have a family emergency*
- *You cancel 24 hours in advance*

Failure to pay the missed appointment fee will result in a disruption of your therapeutic process until the outstanding balance has been cleared. Two consecutive missed appointments may also result in the closure of your file and a referral to another service provider.

Please do not arrive early for your appointment or bring additional persons that are not taking part in your therapeutic process. We schedule 10-minute intervals between sessions to minimize the likelihood that clients will meet each other as they arrive and depart to try our best to ensure client confidentiality.

FEES

The fee for individual therapy is in line with the recommended rate of the *Psychologists' Association of Alberta,* and the current rate for psychological services for individual treatment or assessment is $190.00 per hour.
****A sliding fee schedule is available to those clients without insurance coverage. Proof of income may be required.*

http://www.psychologistsassociation.ab.ca/site/recommended_fee_schedule

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**The following fees apply unless the client's sessions are covered, in their entirety, by a designated Employee Assistance Program.*

Service	Fee
Individual Therapy/Assessment	$190.00/hr
Family and Couple Therapy	$190.00/hr
Group Therapy	$70.00/hr
Reports/Letters	$190.00/hr
Late Cancellations (Less than 24 hours notice)	$190.00/hr
Missed Appointment	$190.00
Equine Assisted Therapy	$220.00/hr
Expert Witness Testimony (half day)	$1200.00
Expert Witness Testimony (full day)	$2400.00
Legal/Access & Legal/Forensic Assessment	$1200.00
Copy of Client File for Educational/Medical Supports	$50.00
Copy of Client File for Legal Purposes	$240.00

- Report writing, telephone consultation, letters and form completion is billed at the rate of the service being provided
- Billing can also occur in 10 minute increments for services done outside the therapy hour such as phone calls, letters and the like calculated at one-fifth the hourly rate for each 10 minutes. Incremental billings are also appropriate for services provided beyond a 50 minute session.

Payment can be made at the end of each session by either Cash, Cheque, VISA, Mastercard or American Express.
There will be a $50.00 fee for returned cheques.
Delinquent accounts will be forwarded to *MetCredit* for recovery.

Rate of Hourly Service Agreed Upon with Attending Clinician: ___________________ ___________________
CLIENT INITIALS

RECORD KEEPING

Confidential progress notes are kept for all sessions. Clinical records are stored and maintained electronic format (OWL Practice database) with the exception of consent forms, which are kept in a locked filing cabinet. The information collected is to contact you personally, and to assess your needs. Should you wish to access your clinical files, you may do so by completing a formal request to your clinician. If two or more individuals attend a counselling session/s, written records of the session/s may not be released to any parties unless written consent is given by each individual who attended. Clinical records are maintained for 10 years.

ANIMAL ASSISTED THERAPY (CANINE)

*FOR CLIENTS ENGAGING IN THERAPY SERVICES WITH A CANINE PRESENT ONLY

I acknowledge that I have been thoroughly advised by my therapist regarding the risks and benefits of animal-assisted therapy. My therapist has answered any question I asked regarding this nontraditional therapy and explained other kinds of therapy that are available to me. After adequate time to consider what is in my best interests/my child's best interests, under their present circumstances, I knowingly and voluntarily agree to participate in animal-assisted therapy/ allow my child to participate in animal-assisted therapy.

______ I have no known animal-related allergies

______ I have allergies (I acknowledge the use of this therapy despite such allergies).

______ My child has no known animal-related allergies

______ My child has allergies (I acknowledge the use of this therapy despite such allergies).

I agree to hold the assigned therapist and Family Counselling Centres Inc. and all of its successors, assigns, subsidiaries, affiliates, officers, directors, employees, and agents completely harmless and not liable, and release them from all liability whatsoever on account of or in connection with any claims, causes of action, injuries, damages, cost or expenses arising out of the use of or presence an animal during my/my child's therapy.

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PARENT/GUARDIAN SIGNATURE	PRINT NAME	DATE

SATISFACTION WITH SERVICES

Our organization is committed to ensuring the best possible to care to those in our community. Accordingly, our Facility Director, Tammy Schamuhn (tschamuhn@familycounsellingcentres.com), may choose to contact you through the email address you provided to ensure you are happy with the quality of care our clinic(s) and its clinicians provide. Please know your response is entirely optional.

CONFIDENTIALITY

With the exception of my clinical supervisors and team, all disclosures made in session are confidential and cannot be disclosed to a third party without your written consent except in the following potential cases.

a) *Imminent danger to yourself or others.*
b) *Suspicion of abuse or neglect of a vulnerable person such as a child, elder or mentally challenged adult.*
c) *Court subpoena.*
d) *Defending a malpractice suit.*
e) *Collecting unpaid fees, which will be forwarded to Met Credit Collections.*

By signing this document I am indicating that I understand and agree with the above conditions of treatment, and my therapist has answered any questions I have about items listed in this consent form or about the counselling process.

CLIENT SIGNATURE	PRINT NAME	DATE
THERAPIST SIGNATURE	PRINT NAME	DATE

*TREATMENT OF A MINOR (IF APPLICABLE)

This is authorization for____ to provide therapeutic services to my child/adolescent:
CLINICIAN NAME, TITLE

CHILD'S NAME:____ DATE OF BIRTH:____

By signing this Consent for Treatment I am indicating that I understand and agree with the above conditions of treatment, and my therapist has answered any questions I have about items listed in this consent form or about the counselling process.
I am also certifying that I legally have custody or joint custody of my son or daughter and, thus can legally consent for the treatment of my child.

PARENT/GUARDIAN SIGNATURE	PRINT NAME	DATE
PARENT/GUARDIAN SIGNATURE	PRINT NAME	DATE
THERAPIST SIGNATURE	PRINT NAME	DATE

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CREDIT CARD AUTHORIZATION

CLIENT NAME: ____ DATE OF BIRTH: ______________________________________

CARDHOLDER NAME: ____ TYPE OF CREDIT CARD:

BILLING ADDRESS: ____

☐ MASTERCARD

____

☐ VISA

____

☐ AMERICAN EXPRESS

____ CARD NUMBER

_______/______ EXPIRY DATE

_________ CCV

This is to authorize Family Counselling Centres Inc. to charge the agreed amount listed below to the credit card provided herein. I agree that I will pay for the cost of services in accordance with the issuing bank cardholder agreement for:

- ☐ Therapy/Assessment Sessions $___________/hr
- ☐ Late Cancellations/Missed Appointments (*In accordance with FCC Policy outline in consent*) $________
- ☐ Insurance CoPay (ASEBP, Blue Cross, Greenshield, FCSS, FSCD, Other: _________) $_______/________
- ☐ Denial of Benefits (ASEBP, Blue Cross, Greenshield, FCSS, FSCD Other: __________________)

____ CARDHOLDER SIGNATURE

___________________________ DATE

SEND RECEIPT OF CHARGES TO: ___________________________________

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