### CONSENT FOR COUNSELLING WITH BETH MARES RP

# First Middle Last Date of birth: yyyy-mm-dd \_\_\_\_\_ Home phone \_\_\_\_\_Business phone \_\_\_\_\_Cell phone \_\_\_\_\_ Email \_\_\_\_\_ Address \_\_\_\_\_ A confidential message may be left at/sent to \_\_\_\_\_\_ Family doctor \_\_\_\_\_\_Phone number \_\_\_\_\_ Emergency contact person \_\_\_\_\_\_Phone number \_\_\_\_\_\_ Referred by: \_\_\_\_\_\_ Status # (NIHB clients only) \_\_\_\_\_\_

### **Declaration:**

Full legal name

I am over 18 years of age. I am currently living in English Canada or I am a permanent resident of English Canada.

In the past year I have not threatened or planned suicide or homicide, engaged in self-harming behaviour such as cutting or burning, had a mental health emergency, used illegal drugs or been involved in violent or organized crime.

I am aware that my counsellor does not do reports or write letters for custody. I agree that, should I be involved in legal proceedings, neither I nor my lawyer(s), nor anyone else acting on my behalf will call on my therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless it is by mutual consent.

In order to protect my counsellor's privacy, I will not share any electronic or other records of our work together without her written permission.

I have read the privacy policy at https://www.therapytorontotherapist.ca/beth/privacy-policy.htm

### **Cancellations:**

I will pay for any sessions cancelled less than 24 hours in advance for any reason. (The charge is half if at least 3 hours notice is given.)

# **Emergencies:**

I understand that my counsellor does not provide emergency services and that in case of an emergency I should call a crisis line or 911.

## **Informed Consent:**

I am aware that treatment for any disorder or dysfunction requires my informed consent, which I can withdraw at any time, and that I am encouraged to ask any questions I may have about how a treatment works, the expected results, any risks, alternative treatments, or the likely results of no treatment.

# **Confidentiality:**

I am aware that

telephone messages and most email correspondence are not secure and can be intercepted

my counsellor advises clients that counselling may be rendered ineffective if they reveal the content of their sessions to family or friends, especially within 24 hours of the session

my counsellor will not be able to maintain confidentiality when she is obligated by law to do otherwise, or when she believes that someone is in danger of bodily harm

# Remote sessions via internet or telephone

I understand and agree that

Potential risks include interruptions caused by technological problems and a possibility of unauthorized access.

If the video conferencing is not working adequately, we can do it by phone or instant messaging, or finish the session early.

I will ensure that I am in a **private location** in which I cannot be overheard and in a **safe place** (e.g., not while driving). If I am not at my usual location, I will inform my counsellor at the beginning of the session.

Name	Date
information is correct.	y that I have read and understood this form and that all the

Download first to your computer, then fill out, save and email as an attachment.