Informed Consent to Service, Fee Schedule, and Limitations to Confidentiality *Kristin Edstrom*

Registered Clinical Counsellor #8781
250.808.0045
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In my work I have found that it is best to clearly specify the form and content of the relationship that you and I (or you as a parent, your adolescent, and myself) may enter into by drawing up a list of clearly defined treatment agreements. I am completely committed, both professionally and personally, to provide you with the highest quality of service. This contract, or list of treatment agreements, is an aid to help you receive the service that you desire. It is also your assurance that I am well aware and respectful of your basic rights to know the exact nature of your treatment. If you are seeking treatment for yourself, and you are an adult (age 19+ years in B.C.), then your informed consent, and completion of and signature on this form is required. If you are seeking treatment for your child who is under the age of 19 years, then my preference is for both parents who have parental authority over the child, as well as their child, to complete and sign this form. If only one parent accompanies their child to the initial session, then I will, with your child's consent contact the other parent so that I have an opportunity to review the plan for treatment with them and he/she has an opportunity to ask any questions. Please carefully consider the terms of this contract and feel free to discuss any of the agreements with me. It is important to understand that I will only provide services to you following obtaining your informed consent, which includes an understanding of your rights, and the benefits and risks associated with these services. By signing this contract, you and I will have agreed to fully participate in the services described unless we mutually agree to revise, or add to, any of the provisions, or until you choose to terminate the service. If you decide at any time to not receive services from me, I am happy to provide you with the names of other qualified professionals. You should know that a Registered Clinical Counsellor is not a physician and I cannot prescribe or provide you with any medication or perform any medical procedures.

Fee Schedule

British Columbia's Medical Services Plan does not cover my fees.
Regular sessions (Family and/or individual psychotherapy) - **$135.00** per psychotherapy session of 50 minutes or portion thereof.

Cancellation Policy

You will not be charged if you cancel sessions with more than 24 hours advance notice. That means speaking to me directly or leaving a message at 250.808-0045. For sessions cancelled with less than 24 hours advance notice, or you do not attend, the full regular fee will be charged. Another appointment will not be arranged until the missed appointment fee has been paid. If you do not show up for your appointment, I will wait for you, assuming you are late. If you are late, the session will end at the regular time (10 minutes to the hour) and you will be charged the full session fee as that session's time has been reserved for you. My voice mail is on at all times. Illness and sudden emergencies are certainly understood.

Payments
All clients are required to pay for services immediately following each session, or at the time the services are received. I do not direct bill third-party payers such as insurance companies. Although I will do what I reasonably can to support and help clients obtain third-party reimbursement of fees paid, the client remains personally responsible for obtaining any reimbursement for which they may be eligible. The client pays for therapy directly to me and then he/she may be reimbursed if they have an arrangement with a third-party payer. All inquiries with insurance companies will be made by the client.
I accept cash in exact amount or personal cheque. If your personal cheque is returned, you will be responsible for all fees associated with the cheque return.
Receipts are usually prepared at the end of each session.

Benefits of Therapy
Therapy can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems, such as anxiety, anger, depression, an eating disorder, stress, or relationship concerns. Therapy can help a person to develop new skills and to change behaviour patterns, and to become better self-regulated. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others, thus allowing you to experience more satisfaction from those relationships.

Risks of Therapy
It is important to understand that there is no guarantee of a successful outcome from therapy and that there are some risks, such as experiencing unpleasant memories and/or difficult thoughts and emotions, such as fear, anger, anxiety, depression, frustration, and loneliness. Therapy will likely involve trying out new behaviours and changing ways of relating to others.

Voluntary participation and ending
Your participation in this service is voluntary. You may refuse to engage in any activity, to ignore any advice and end your involvement at any point and for any reason. You may at any time ask to be referred to another clinical counsellor or care provider. You understand that if progress has not been obtained I may end the therapy and will help you find alternative services.

Confidentiality
You understand in general that the information obtained during the process of therapy is confidential and will only be released to others with your explicit written consent. If there are any issues regarding confidentiality, such as payment for services by a third party who is requesting information on the treatment, I will clarify these issues as much as possible prior to beginning to provide services or when this issue becomes apparent. You should be aware that if you are submitting claims to an insurance company, that company may require information on your treatment, as may an Employee Assistance Plan.
You understand that as part of routine practice I may on occasion consult with colleagues regarding your situation, and that if I do so it is for the purpose of benefiting you and your confidentiality will be preserved.
There are legal limits to confidentiality when a Registered Clinical Counsellor must report

concerns to the appropriate person (including a parent or guardian if you are an adolescent) and/or agencies. You should understand this prior to sharing personal information in a therapy session. These include (but may not be limited to):

• You/your child, or any other person, is at risk of being abused or neglected, for example when someone is hurting a child or not giving them what they need to live and be safe.

• You/your child tells the counsellor that s/he plans to cause serious harm or death to themselves, or to someone else, and the counsellor has reasonable grounds to suspect that s/he has the ability to carry out this threat in the near future.

• With an adolescent I will not treat marked deterioration due to an eating disorder, or severe self-harming behaviours, as confidential. Parents may be informed, depending upon the situation and my professional judgement.

• A person has a condition which makes it dangerous to drive, and keeps on driving even though the counsellor tells them it's too dangerous (as per the Motor Vehicle Act). • A court orders that information and reports in the counsellor's file be released to the court. • A person tells the counsellor about the behaviour of another health professional which might cause danger to them or someone else if it is not stopped.

Family Physician Contact

You understand that I may contact your Family Physician, that I may forward a form to him/her to complete and return, and that I may stay in contact with him/her throughout your treatment. As part of signing this contract, you give permission to me to discuss aspects of your progress with your physician. I may require you to have a physical examination before we proceed with therapy, and at times throughout our working together.

Complaints

I am a registered member of the British Columbia Association of Clinical Counsellors (BCACC) and as such am governed by the Association's *Bylaws* and *Code of Conduct*. The mandate of BCACC includes protection of the public, and the responsibility to investigate complaints about a service received from a Registered Clinical Counsellor. Information may be obtained from the BCACC regarding the laws, the Code of Conduct, and guidelines governing the provision of therapeutic services. If you have any concerns about my conduct or any aspect of the treatment, you may discuss these concerns with me at any time during the course of treatment. You can make a formal complaint about the process of therapy to the BCACC, 14-2544 Dunlevy Street, Victoria, BC V8R 5Z2 (www.bc-counsellors.org).

Contact

You can contact me via e-mail (edstromkristin@gmail.com) or leave a message on my cell phone at 250.808-0045 at any time. However, it is understood that it may take some time for me to return your call. If it is a crisis you are experiencing, you understand that it may be best for you to call your family doctor or go to the nearest hospital emergency room.

Contract agreement

You have carefully reviewed this document and have had sufficient time to consider it. You understand this document in its entirety, have been given a copy of it if requested (Yes___ No (declined) ___), and agree to its contents and to abide by its terms of service. You have had the opportunity to ask any questions or concerns arising from it, and understand that you can

ask any questions throughout your assessment/treatment.
Any services you receive will be specific to your situation and needs, and while I will make every effort to answer any questions related to your treatment, I may at the outset not be able to answer all the specifics. If you wish to stop counselling at any time, all you have to do is tell me. However, if you do at any time wish to stop, I would ask that we have an opportunity to meet to discuss this rather than just no longer coming to therapy. Based on this information you hereby give your fully informed consent to participate in therapy, or for your adolescent to participate. Please complete section A, B, or C below as appropriate.

(A) If You are at least Age 19 Years and Seeking Treatment for Yourself:
Please sign directly below if you are competent to provide informed consent.

_____ _____
Client Signed Date

(B) If You are Parent(s) Seeking Treatment for Your Adolescent: Please complete the following:

I, _____, mother/father of _____
(first parent's name) (choose) (adolescent's name)

age_____, born on _____, and I

_____
_____, (second parent's name)

father/mother of the adolescent, agree to treatment provided by Kristin Edstrom, Registered Clinical Counsellor.

Signature of the first

parent_____Date_____ Signature of the

second parent_____Date_____

(C) If You are an Adolescent:
By signing this form, you are indicating that you understand everything in the form and wish to begin therapy. If you do not understand anything on this form, please ask and I will be happy to explain it further to you.

Your Signature_____Date_____

I, Kristin Edstrom, confirm that I have on this _____day of_____, 20_____,

explained the contents of this document to the client (and parent(s) if appropriate) who has (have) signed this Informed Consent to Service, Fee Schedule, and Limitations to Confidentiality.

Kristin Edstrom_____ Date:_____