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CONFIDENTIALITY CONTRACT

If you have any concerns about these matters, or about this form, please discuss these with me.
Please INITIAL the BOX at the end of each topic.

Confidentiality:
All information disclosed within sessions is confidential and **will not** be revealed to anyone without written permission, **except as listed below** or where reporting is required by law, such as:

1. Where there is suspicion that a child or children (**PRESENTLY** under the age of 16) has been or is being abused,
2. Where the client presents a serious danger of violence to others,
3. Where the client is likely to harm themselves unless protective measures are taken,
4. If a client reveals that they have has been sexually abused by a health care provider who is covered by the Regulated Health Professions Act (for example, a psychologist, a nurse, a physician), the counselor is obliged to report the name of the perpetrator to the governing body. ☐

Consultation: I/we understand that the therapist will be consulting with clinical consultants/clinical supervisor on a regular basis; that the information provided by the client will be handled professionally and confidentially. ☐

Court Appearances: I/we understand that the therapist will not appear at, or participate in court proceedings. Therefore I/we agree to not request this of my/our therapist. ☐

Technology: I/we agree to be contacted through cellular phone/email/ or text for the purpose of appointment scheduling and follow up only. I/we understand that our therapist will not be immediately available by any of these methods. I/we acknowledge and understand that all of these methods of communication are not 100% securable, and by agreeing and using these methods of communication, I/we are acknowledging informed consent of the possible confidentiality risks. ☐

Fees/Cancellations: I agree to the fee of **$160.00 ($168.00 includes 5%GST)** per clinical hour (50 minutes) therapy session, **$240.00 ($252.00 includes 5%GST)** per clinical 1.5 hour (75 minutes) therapy session.

I understand the **full fee for missed/cancelled appointments with less than 48 hours notice** will be charged to my account, and is payable in advance of the next session. I also understand that for short notice cancellations, I will contact my therapist directly by telephone or text and leave a short message if my therapist does not answer. **Please note that fees maybe be subject to annual increases – you will be notified a minimum of two months in advance of increase.** ☐

Agreement: I/we understand and agree to all the policies as presented above, and the next two pages. ☐

Client/s signature: **Date:**

_____ _____

_____ _____

Therapist signature:

_____ _____ _____

AGREEMENT FOR VIDEO CONFERENCE AND/OR TELEPHONE THERAPY APPOINTMENTS

I understand that In-Person Sessions are not currently available at this time, and that should they become available I will be required to receive clear explanation of the benefits and risks of attending in-person to the extent of my therapists understanding.

I confirm that Murielle Jennings, MMFT, CCC, RMFT has offered me therapy sessions via video conferencing and/or telephone and I have agreed to this. I confirm having had clear explanations of the benefits and risks of using these technologies to the extent of my therapists understanding.

Risks and Benefits:
I understand that in addition to the risks and benefits of therapy in general, doing therapy remotely has the potential benefits of easier access to care and meeting in a location of my choosing. The potential risks include interruptions, technical problems and the potential for unauthorized access.

My therapist has explained to me that there has taken reasonable care to ensure the technology used is safe, appropriate and reasonably secure. I understand that landlines are thought to be the most secure telephone option with cordless and mobile phones offering less security.

I understand that if the video conferencing technology is not working properly, my therapist or I can suggest completing the session over the phone or ending the session earlier than usual. My therapist is not responsible for troubleshooting technological problems during the course of the remote session.

As this agreement entails continuing therapy though not in an office, I agree that I will ensure that I am in a location that is as confidential as being in an office, to prevent being overheard. **To minimize disruption, I will turn off text message and all mobile phone and/or computer notifications while meeting**.

If I am usually in my home or office for my session but have relocated for a particular appointment, I will tell my therapist where I am at the beginning of the sessions.

If, during the course of the session, it becomes clear that I am experiencing a mental health crisis, my therapist, or I may use the session to establish a safety protocol or reach out to my emergency contact or other emergency services if this seems necessary.

I may revoke the agreement to use phone or video conferencing technology for my sessions with my therapist at any time.

Please sign below as acknowledging and accepting your responsibility below:

Client/s signature: **Date:**

_____ _____

_____ _____

Intake Questionnaire

Thank you for filling out this questionnaire. It will help me to more quickly understand your past and present situation.
Please circle/or put X for the type of therapy you seek: Family _____ Couple/Union_____ Individual_____

Identifying Information

Surname & Given Name: _____Gender: _____ Date of Birth: _____
Surname & Given Name: _____Gender: _____ Date of Birth: _____
Current Address/s:_____
_____
_____
Email: _____
Day, Evening and Cell phone numbers: _____
May I telephone/text you at these numbers? _____
Which is the preferred contact number? _____May I leave a message/VMail?_____
Who referred you to me? or how did you learn of my services?_____

Other Information

Workplace/Occupation: _____
Gross Family Income: _____
Relationship Status: _____
Living Arrangements: _____
Education: _____
Religious Affiliation: _____

Children (to be completed by parents)

Name _____ Gender _____ Date of Birth _____
Name _____ Gender _____ Date of Birth _____
Name _____ Gender _____ Date of Birth _____

Health Information

Have you experienced therapy/counseling before? If yes, please provide a brief description of date, duration and the reason for attending.

Have you or are you currently seeing a Psychiatrist/Physician? If yes, please provide their full Name, address and telephone number.

Are you on any medications, prescribed or otherwise?
Please provide the name, dosage, and reason.

Are there any other agencies involved?

Is any of your family involved with psychiatrists/therapists or other agencies?

Are there any serious illnesses in your family that are affecting your current challenge?

Please provide an emergency contact: full name, address, telephone number and relationship

1. Briefly state the reason you are seeking help at this time, and what you would like to change.

2. To the best of your knowledge describe when these problems began

3. What do you believe is/about the cause of these problems?

4. What do you believe will change (feelings, thoughts, behaviour) once you have found reasonable solutions to the problem? How will your life be better?

5. What are your relationships currently like? Please describe feelings and concerns

6. Is there any other information you would like me to know? For example, what are your strengths? Support system/s?

SIGNATURE: My signature confirms that I have freely given this information about myself and my I understood that it will be used as declared on the "Confidentiality Therapy Contract".

Signature: _____ Date:_____

Signature: _____ Date:_____