Confidential Client Intake Form

Please fill out the following fields as completely as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it blank, please feel free to do so.

Name: ____

Address: ____

City:______________________ Prov.______________: Postal Code:_______________

Home phone: _______________________ Cell: _______________________________

Email: ____

Age: __________ Gender: _________ Birth date: _____________________________

Current occupation: ____

Person to alert in the event of medical emergency: ______________________________

Relationship to you:_________________________ Phone: ______________________

Family Doctor: ____________________________ Phone: ______________________

Relationship status (circle one):

Single Married Partnered Separated Divorced Widowed

Spouse/partner's first name: _______________________ Years in relationship:_______

Children (gender, age): ____

____

Please describe any significant current or past medical problems: __________________

____

Please list any medications you currently take. Include prescription and over-the-counter medications/supplements and the dosage of each: ______________________________

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____

Informed Consent :

I, _________________________________ hereby consent to receiving registered provisional psychological treatment with the following understanding:

It has been disclosed and understood to the client, that Jill Zurevinski is a Registered Provisional Psychologist with the College of Alberta Psychologists.

____ (client signature)

Confidentiality

I understand that all information shared with my therapist is confidential and no information will be released without my written authorization. I understand that any personal information that is collected is done so under the Health Professions Act, the Personal Information Protection Act (PIPA) and the Freedom of Information and Privacy Act (FOIP). The purposes of collecting fees, mailing forms, and arranging appointments will not be released to other third parties or used for any other purpose than those outlined within this document.
Verbal consent for limited release of information may be necessary in special circumstances, which will be discussed and attained prior to any action taken with my personal information. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, my therapist is ethically and legally bound to take necessary steps to prevent such danger. This may include contacting relevant authorities, even if I do not wish my therapist to do so.
- When there is a reasonable suspicion that a child, elder, or any vulnerable person is being sexually, physically or emotionally/psychologically abused, neglected, or is at risk of such abuse, my therapist is legally required to take steps to protect the person and to inform the proper authorities.
- All other requests for my personal information to be either released or obtained by my therapist or other professionals (e.g., my family physician, lawyers, etc.) will be discussed as they arise and will require my written permission to comply, unless ordered by court.
- In cases where I have elected to see my therapist out of multiple offices, I understand that this requires the physical transfer of my file, which may jeopardize my confidentiality (i.e. in the case of a vehicle collision or theft).

Therapy agreement

I understand that I am eligible to receive evidence-based treatment in the form of individual therapy. The type and extent of service that I will receive, will be collaboratively determined thorough discussion with me.
I understand that I am free to discontinue these services at any time, without penalty or prejudice (with the exception of late cancellations/no shows as identified below) and that I

am encouraged to discuss either a change in therapist, approach, or a referral to another professional with my therapist, to ensure that I receive the best care possible.
I understand that this consent will remain in effect until such a time as I withdraw it via written consent, or discontinue services with my therapist by informing them of my intent to do so.

Attendance

Individual therapy sessions are between 50 and 60 minutes in duration. Session frequency can vary over the treatment period. I understand that unexcused no shows or cancellations with less than 24 hours notice, a credit card is required to reschedule. If appointment is missed again, then 50% of the appointment cost is charged.

Financial agreement

I understand and accept that my session fee is $190 per visit for face-to-face, online, and telephone therapy/consultation session (which entails 50 to 55 minutes of meeting time and 5 to 10 minutes of report writing time for each session, but excludes initial telephone, in-take, or scheduling time). I also understand and accept that other billable services, such as report writing, professional letters, form completion, and review of written records from other specialists are billed at $190/hour, unless made known to me otherwise.
Service fees are tax deductible and a receipt upon payment. I understand that should I be unable to remit full payment for any outstanding fees and charges owed, I will not be able to book and access any further services such a time.

________ please provide your initials indicating agreement with above financial agreement.

Risks and benefits

I understand that while psychotherapy may provide significant benefits based on empirical evidence, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recollection of troubling memories. I also understand that choosing not to engage in therapeutic treatment may also result in greater discomfort or escalating risks. It has been explained to me that my feedback and communication about the therapy process and impact is crucial in reducing my risk for harm, and my therapist has encouraged me to communicate any concerns or discomforts with them, as soon as is feasibly possible in my treatment. I also acknowledge that therapy is most effective when I am comfortable with my therapist and so, should I not feel comfortable or connected to this therapist, I will either request a transfer to another individual or make my concerns known in order to best facilitate care for myself.

Rights and responsibilities

I have a right to be treated with respect, dignity, and without discrimination, regardless of my age, gender, mental and physical status, sexual orientation, race, belief system or

ethnic background. I can expect my therapist to make their best effort to conduct therapy as competently as possible. I have a right to ask questions at any time, be informed by my therapist as to their qualifications, areas of specializations and limitations, and the code of ethics which they follow. I have a right to be advised as to the limits of therapeutic service, discuss my treatment with others (including getting a second opinion), and have been informed of the College of Alberta Psychologists' grievance procedures. I understand that I may stop treatment at any time. I understand that I have a right to view my file notes at any time and to know what is being recorded about me.
I understand that I am responsible for setting therapeutic goals for my treatment and review them as required. I will cooperate with my therapist in evaluating the treatment process and work toward achieving my self-identified goals.

I have read and understand the above information and agree to these terms. This consent form expires upon completion of the intervention unless revoked by me in writing prior to that date.

Client Name: (Please Print) ____

Signature of Client or Guardian: ____

Date: ______________ Signature of Jill Zurevinski ___________________________