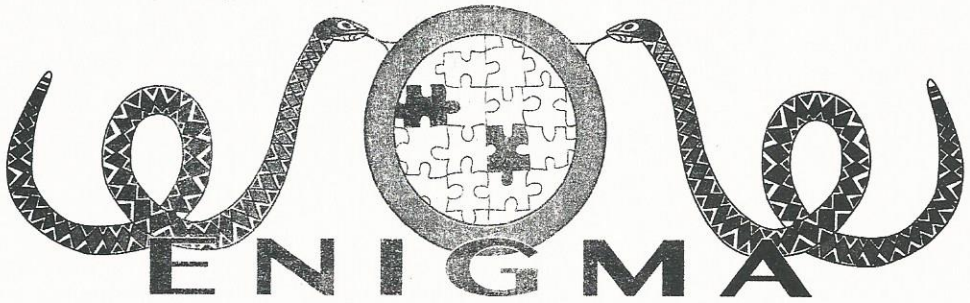

Physical, Emotional & Mental Health Studio

Name(s): _____

Date(s) of Birth: _____

Address: _____

City and Province: _____ Postal Code: _____

Phone: Home: _____ Cell: _____

Work: _____ Ex: _____

I wish to receive newsletters/updates by e-mail: YES ☐ NO ☐

I/We hereby acknowledge that the fee policy has been explained to me/us and that I am/we are aware and in agreement that;

1. the fee is **$170.00-** for each 50 minute session;
2. if I/we do not keep an appointment and fail to give **24 business day hours notice of cancellation**, I/we will be **billed for the appointment in full ($170)**. Please note that insurance companies do not cover late cancellations or no shows and you will not be able to submit for reimbursement. _____ (Please initial that you have read this).
3. there will be no billing of fees, rather I/we will pay for each session by Visa, Master Card, Debit, cash or cheque.
4. A fee of $20 will be charged for any NSF cheque written by me/us. I understand that I/We will be liable for an additional $35 (to partially offset the agency's fee) if it is necessary to turn our/my account over to a collection agency;
5. I agree that it is my/our responsibility to ascertain if psychological services are covered under my supplemental health insurance plan.

I/We have read and understand this Agreement.

Signature: _____ Date: _____

EMAIL: _____

Referred by: _____ Family Physician: _____

301-255 Lacewood Drive, Halifax NS B3M 4G2
p: (902) 495-3181 f: (902) 495-3182
www.carolshirley.ca info@carolshirley.ca

Physical, Emotional & Mental Health Studio

I/we, _____ give the administration staff at Enigma permission to send a form letter to my Family Doctor, indicating the fact that I have attended a counseling session with my Psychologist.

I further understand that no additional communication will happen without my expressed written Permission, which will be given upon my request for follow-up information.

By signing I am indicating that I understand that the letter sent will be kept in my medical record and can be accessed by anyone who has access to my medical records.

Signed: _____ Date: _____

Witness: _____ Date: _____

Doctor's name and address:

_____

_____

_____

_____

301-255 Lacewood Drive, Halifax NS B3M 4G2
p: (902) 495-3181 f: (902) 495-3182
www.carolshirley.ca info@carolshirley.ca

ENIGMA

Physical, Emotional & Mental Health Studio

Informed Consent

1. Nature of Services: Treatment usually involves talk therapy along with psychotherapy tasks between sessions if appropriate.

2. Length and Frequency of Sessions: A single session is 50 minutes long. Double sessions are an option (1 hour 50 minutes) if you would find that helpful. How many sessions and how often you come to session, will depend on your personal needs.

3. Confidentiality: I will not provide information about you or your treatment to others without written permission except in cases where I am required by law.

Please understand that if I am concerned that you will attempt suicide and you are not willing to agree to a plan or if you threaten to kill or do something violent to another person or if you tell me about a child or vulnerable adult who is being harmed or at risk of harm, please understand I am required by law to violate confidentiality and to act to protect the safety of the potential victim.

4. Legal Issues: If you are involved in legal action, such as divorce proceedings or a lawsuit, I will not testify on your behalf or provide copies of my records of our work together unless I am legally forced to do so by a judge.

5. Other Third Party Involvement: If you are seeing me because you are required to by someone else (e.g., your employer, Worker's Compensation, etc.) or you need a letter or assessment for some purpose, please let me know in our first session.

I/We have read and understand this Consent for counselling form and agree to enter counselling. I further understand that I/we may revoke our/my consent at any time by providing my intentions in writing to my personal psychologist.

_____ _____

_____ _____

Signature of client/Legal Guardian Date

301-255 Lacewood Drive, Halifax NS B3M 4G2
p: (902) 495-3181 f: (902) 495-3182
www.carolshirley.ca info@carolshirley.ca