I,       (please print name) have read the “Information Sheet for Counselling Services” form provided and asked any questions I had and understand it. Specifically, I understand:

*(please check boxes):*

The nature and process of counselling, potential risks and benefits, and my rights and responsibilities as a client.

The credentials of my counsellor.

That I can stop or refuse any requests or suggestions made by my counsellor.

The limits to confidentiality including that if I disclose information indicating that myself or someone else is at risk of imminent, serious harm my counsellor is required to breach confidentiality.

How my information is documented and stored including the use of emails and the Wave app invoicing system.

I understand the nature, risks and process related to counselling via Videoconference and/or

Phone and that my counsellor cannot guarantee privacy when conducting counselling via

Videoconference or phone.

The complaint process.

The fee of $160 is due immediately after the session ends and is payable via e-transfer, cash

or cheque.

If there are a frequency of no-shows and/or late cancellations my counsellor may discuss this with me and I be required to pay for unattended sessions.

Heather does not provide emergent, crisis care. If I am at risk of harm to self or others I agree to contact the distress line at 403 327 7905, 911 or a supportive person in my life that I can ask to help me calm and enhance my safety.

I give consent to participate in counselling and agree to engage in therapy under the conditions outlined in this document. I am over the age of 18 or have been designated a mature minor.

For Counsellor’s use:

* I, the Counsellor, have discussed the issues and consideration within this form with my client.
* My observations of this client’s behavior and responses indicate that he/she/they understands the conditions in this document and is competent to give informed and willing consent at this time.

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Counsellor Signature Date

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| --- | --- |
| Client Signature: | Date: |