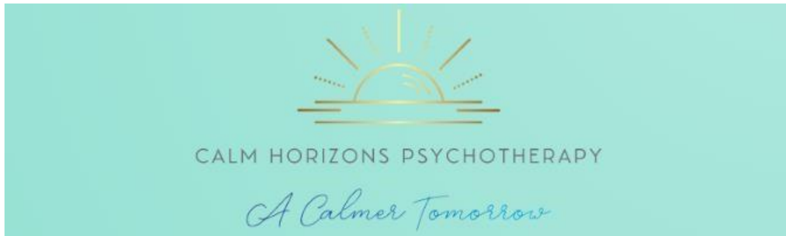


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(289) 799-2289
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**Please initial where indicated to verify this form was sufficiently explained.**

| Name:<br>Preferred Name: |
|---|
| Date of Birth: |
| Start Date: |
| Referral Source: |
| Address: |
| Emergency Contact (Relationship/number): |

**What is psychotherapy?**

"The practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication" (Psychotherapy Act, 2007, Section 3). In a therapeutic relationship, techniques are delivered to improve impaired judgement, insight, behaviour, communication or social functioning due to a disorder of thought, cognition, mood, emotional regulation, perception or memory.

______ Client initials

**Client–Therapist Therapeutic Relationship**

"The client-therapist relationship is the foundation of psychotherapy. It is central to the provision of safe, effective and ethical care" (CRPO).

I understand that this is a therapeutic relationship. I understand that the exchange and receipt of gifts is not permitted. I understand my therapist will demonstrate trust, care, compassion, kindness as well as empathy and I will not misinterpret care for friendship or romance.

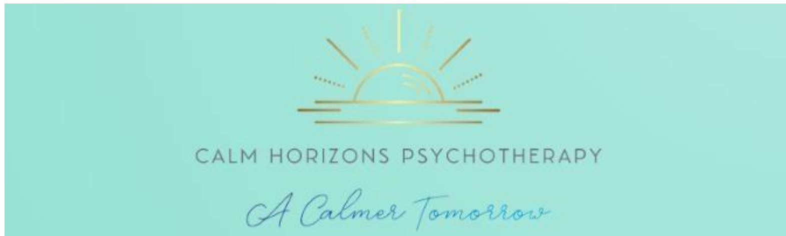
______ Client initials

**Confidentiality**

I understand that my confidentiality will be protected according to The Personal Health Information Protection Act, 2004 (PHIPA). I understand that any information related to myself will not be released without my written consent. I understand that there are limited legal circumstances in which my consent to release information is not required. These legal circumstances include:

- When the therapist believes there is imminent risk of physical or psychological harm to a client or others (in which
- case it is a legal duty of the therapist to warn the other persons whose safety is in jeopardy).
- When the therapist has reasonable grounds to suspect that a child or dependent is in need of protection due to
- physical harm, neglect or sexual abuse.
- Where necessary for particular legal proceedings (e.g. when the member is subpoenaed).
- To facilitate an investigation or inspection if authorized by warrant or by any provincial or federal law (e.g. a • criminal investigation against the member, his/her staff, or a client).
- For the purpose of contacting a relative, friend or potential substitute decision-maker of the client, if the client is
- injured, incapacitated or ill and unable to give consent personally.
- To a college for the purpose of administration or enforcement of the Regulated Health Professions Act, 1991 (e.g.
- providing information about the client to the College if a complaint has been made against the therapist,
- assessment of the therapist's practice as part of the Quality Assurance Program; mandatory reporting where the therapist's client is a regulated health professional and the member has reasonable grounds to believe that the client has sexually abused a patient/client).

______ Client initials

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**Care Consent**

I understand that I can withdrawal from my consent and/or asked to be referred to another therapist without judgment at anytime. Withdrawal of consent and conclusion of therapy for any reason will be documented in my records.

________ Client initials

**Self-harm**

I am committed to living. I will not harm others or myself in any way. I will not attempt suicide, or any other injury. If I begin to experience thoughts about self-harm, I will:

- Determine whether it is an emergency and if so, call 911
- If it is not an emergency and I can control my behaviour, I will:
- Practice grounding strategies
- Try to identify what is upsetting me
- Review alternatives to self-harm such as: ____________________________________________
- I will try to make myself feel better by: _______________________________________________
- I will seek out a responsible, caring, and supportive person if thoughts continue

________ Client initials

**Email/Text/Phone Call Consent**

I understand that email/text/phone calling are not secure method of communication and will only be used only for the purposes of scheduling and cancelling appointments, or at my discretion. In the event of a mental health emergency, I will call 911 or COAST at 1 866 550 5205 (Niagara)

The email address and telephone number I consent to using for email/text communication is as follows:

Email:_________________________________________________

Phone/Text: ________________________________________

________ Client initials

**Telepsychotherapy**

To create a safe a telepsychotherapy session, it is important to be in a quiet, private space with a secure internet connection. My clinician and I agreed upon the virtual psychotherapy platform, and I understand how to use it and equipment involved. I understand that confidentiality still applies to telepsychotherapy services, and no one will record the session without permission from the other person(s).

I was explained and understand the potential risks and benefits of telepsychotherapy compared to in-person psychotherapy. We discussed a safety plan including an emergency contact and closest ER, in the event of a crisis.

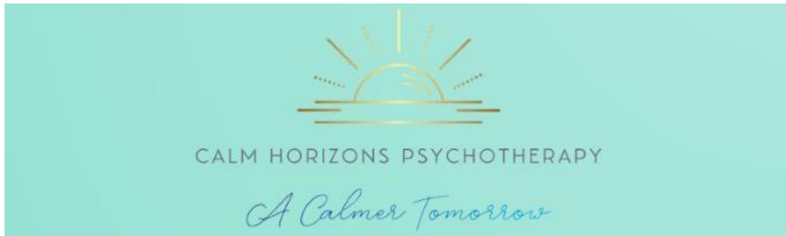
________ Client initials

**Contract**

Based on my identified concerns and goals, I consent to _______ therapy sessions to take place weekly/bi-weekly/monthly (circle one). At this time, concerns and goals will be re-evaluated and extending therapy may be an option and determined on an individual basis.

- I understand that a therapeutic relationship is the foundation of therapy and switching therapists at anytime
- (without judgment) is an option when an optimal client–therapist relationship cannot be achieved.
- I understand I can end therapy anytime, without judgment.
- I understand that benefits of psychotherapy include developing knowledge and skills to manage emotions, manage
- unhealthy responses or behaviours, and to develop coping strategies that will facilitate daily living.
- I understand that risks of psychotherapy include emotional discomfort that may result unwanted thoughts and/or feelings and/or unpleasant dreams.

By signing this form, I ___________________________________________am providing consent to engage in psychotherapy with Kristen Di Martino (MA, Registered Psychotherapist) with a full understanding of what therapy does and does not entail. I agree to adhere to our contract to the best of my ability.

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**Closing File:**
If no appointment is made 1 month following last appointment, without otherwise discussing options, file will be closed. Once files are closed, clients are able to book again; however, this would be dependent on availability and at the rate of new clients booking.

______ Client initials

**Contacting Me**
Please note that I do not check my work phone and work email after hours/weekends. While I do try my hardest to respond to calls, texts and emails promptly, there can sometimes be delays. Services provided are for in session and continuing ongoing support; they do not however, entail things such a crisis support. If you feel that you are in crisis, it is after hours and need immediate support, you can do so by calling the crisis line, COAST at 1-844-972-8338 (Hamilton) or 1-866-550-5205 (Niagara).

______ Client initials

**Payment**
Payment for services with CREDIT CARD (via SquareUp) or E-TRANSFER to kdimartino13@gmail.com is required at each appointment (prior to appointment). I request a credit card be kept on file; this will only be charged if payment is not received and never be charged without your knowledge. Direct billing is unavailable. Subsequent appointments will not be scheduled until payment is received. Services may be discontinued due to non-payment.

Payment for services is $130/hour + HST (13%) totalling: $146.90

**Cancellation/ No-Show Fees**
Cancellation of appointments requires 48-hour notice; if 48-hour notice is not given, a $80 fee will be charged.

Appointments cancelled within 24-hours or a "no-show" of the appointment will be charged the full hour fee of $130/hour + HST (13%) totalling: $146.90

Statements are based on a 50-minute psychotherapy sessions and 10 minutes of documentation.

I understand the billing and cancellation policies.

______ Client initials

**Miscellaneous Fees**
Any legal (lawyers, FACS, parole board, etc.), medical (doctors, work), insurance (including WSIB) or transfer of records will be charged at the hourly rate stated above ($130+HST).

______ Client initials

______________________________ Client signature

______________________________ Date

______________________________ Clinician signature

______________________________ Date

**Kristen Di Martino**, M.A., Registered Psychotherapist | Registration #: 009654

If you feel that any of your ethical rights have been violated, you can report to the CPRO with registration number 009654.