Halle H. Sailer R.P., CACBT
Registered psychotherapist in Ontario (CRPO) – 004706
Canadian Association of Cognitive Behavioral Therapy- member
(M.D. Germany)

Group Therapy, Individual and Family Therapy
Dynamic Psychotherapy, Cognitive Behavioral Therapy
Motivational Interviewing Therapy and Mindfulness

Welcome! I look forward to helping your child's health needs.
Information given in this praxis is fully confidential uless otherwise required by law.

Child and Adolescent Information

Date:	Who is filling this form?

Child Information: **Please Print**	
Last Name:	First Name:
Date of Birth:	Age: Male/Female:
Address (Please print clearly): Street & Nr. City: Postal Code Email: For appointment reminders	**Parents Information / emergency contact:** Mother Name / Surname: Mother Cell: Home nr: Father Name / Surname: Father Cell: Home nr: Emergency contact and tel number:
School Name: Grade: Who lives at home?	**School Services: Current and previous** IEP: Educational Assistance: Tutoring: Counseling at school:
Has been your child treated with psychotherapy? If yes, what kind? Has been your child participated in any group therapy? If yes, where?	Please list (print) all medication that your child is on now. 1. 2. 3. 4. 5.
Referring Doctor: Name:	Tel: Fax:
Family Doctor: Name:	Tel: Fax:
Pediatrician: Name:	Tel: Fax:
Psychiatrist: Name:	Tel: Fax:
Reasons for Referral: 1. 2. 3.	
What are the main concerns/problems at this time: (parental concerns the areas that need improvements) 1. 2. 3.	
What is hoped to achieve/improve or change? 1. 2. 3.	

DECLARATION AND CONSENT:

I, _____ of the following address _____,
acknowledge and declare that I will continue conventional medical care from a medical doctor and that psychotherapy and medical treatments are different but not mutually exclusive. I agree that there has been no suggestion made by Halle Sailer or by anyone under her direction that I refrain from seeking or following medical treatment.

An initial assessment, family therapy, or a one-on-one therapy session is $165 per session (plus HST). Please note that every session is 45 minutes. There will be an extra fee of $45 (plus HST) applied for every additional 15 minutes. You will be asked if you want to continue with the therapy session and whether you want to be charged for any additional time to be taken. This applies only when the added time will not infringe with another patient's booking. It is your responsibility to check whether these services are covered through additional health insurance.

The group therapy program is $80 (plus HST) per session, per person. Prior to your child attending the group program they will first need to be evaluated for an assessment—including a total of two sessions, in order to ensure the group is a good fit.

After finishing individual/group therapy, we recommend a follow-up session once a year to prevent relapse.

If your child is on medication, we recommend not to discontinue the medication without talking to the doctor who prescribed the medication. Please communicate with Halle Sailer if your child wants to discontinue any respective medication.

If your child becomes actively suicidal or has a plan to commit suicide, it is required that you call 911 and/or visit the emergency room immediately. We recommend you take your child(ren) and stay with them during this time.

All information given by you and your child is confidential; unless your child or someone else is in danger. After your initial interview, your doctor will receive a consultation report. This report may be shared with your child's circle of care. Please inform Halle Sailer in case you may have any concerns in this regard.

In case you are unable to keep your appointment and out of courtesy to our other patients, please notify us of any cancellation at least three business days before your booked appointment. As such other patients have the opportunity to book this time slot. Therefore, in case of late cancellations or missed appointments, the full session fee will be charged. In addition, failure to cancel in time will affect access to future sessions.

We use your cell number for the reminders. Please inform us if you don't want to be reminded through your cell number. Thank you.

I am aware and clear about the fees and will pay the fee after every session.
I agree to call 911 and/or visit the emergency room if my child has a plan or becomes suicidal.
I read and understood all points above.

Date: _____ Signature: _____