

Linda Attoe, M.A.

Registered Psychotherapist

CRPO 1686

AGREEMENT OF INFORMED CONSENT I (July 2024)

CLINICAL SERVICES OFFERED

Assessment and treatment of adults who present with a range of psychological and emotional concerns. Services include but are not limited to Psychoanalytic Psychotherapy, Counselling, and Mindfulness-Based Cognitive Therapy.

ASSURANCE OF CONFIDENTIALITY

It is important for you to understand the confidential nature of your relationship with me, your psychotherapist. I will not release your name or any information about you to anyone outside of these meetings without your informed, voluntary and written consent, except as outlined below:

When I am required by law to disclose what would otherwise be confidential information, such as when I believe you may pose a risk of serious injury to yourself or others, there is a suspicion of child abuse as defined by applicable government legislation, you are a member of a Regulated College and break the Standards of that College, or if I am served with a properly executed court order; If you occupy a safety sensitive position in your workplace, I may be obliged to report drug and alcohol concerns to your company's Occupational Health provider in order to ensure employee and public safety; or if my files are audited by the College of Registered Psychotherapists of Ontario.

I am compliant with the Personal Health Information act (PHIPA) and the Personal Information Protection & Electronic Documents Act (PIPEDA).

FEES & CANCELLATION POLICY

There is no OHIP coverage for psychotherapy services in Ontario. My private practice rate for individual therapy is \$135.00 per 50-minute session and I do have a few spaces available at times on a sliding scale. As of June 20, 2024, this fee is **HST exempt**, as regulated by the CRA on that date. Payment is due at each appointment unless other arrangements have been previously agreed upon. Prior to scheduling an appointment, please check with your extended health insurance to determine whether Psychotherapy or Telehealth appointments are included in your coverage. Cancellation policy: Please provide at least 24-hours notice if you need to cancel or reschedule. A fee is charged for late cancels and missed sessions.

CONSENT

I have read and understand the information described above and hereby request to receive clinical services at the mutually agreed upon rate of \$ _____ per therapy hour.

Client(s): _____ Date _____

Psychotherapist: _____ Date _____

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