Consent to Services Form:

This form is to document that I-_____ give permission and consent of treatment to Miriam Klaczkowski, MSW, RSW-psychotherapist and member of the Ontario College of Social Workers and Social Service Workers # 831963.

This service is for me and/or my child/ren, named: _____

Terms of service:

Terms you agree to:

The Provision of services

I understand the therapist will provide an individualized treatment that can include cognitive behavioural therapies such as: traditional EMDR, CBT, DBT, and play therapy.

Cancelled and Missed Appointments and Reimbursements:

I understand that in order to maximize the effectiveness of psychological counselling services, my scheduled counselling sessions should be a high priority and the cancellation of sessions could impact my treatment. I understand that session fees will apply for appointments cancelled less than 24 hours in advance.

Payment for services:

Payment for services is due at the end of each session and a receipt will be given. Please retain this receipt for your insurance, if applicable.

Cost of session is $170.00.

I accept payment via E-transfer to **miriklutch@gmail.com**

Confidentiality:

Confidentiality is respected at all times. No information will be communicated, directly or indirectly, to a third party without your informed and written consent. Exceptions to confidentiality include the legal and/or ethical obligations to:

- Inform a potential victim of violence of a client's intention to harm
- Inform an appropriate family member, health care professional, or police if necessary of a client's intention to end his or her life
- Release a client's file if there is a court order to do so- Inform the Children's Aid Society if there is suspicion of a child being at risk or in need of protection due to neglect, or physical, sexual, or emotional abuse
- Report a health professional who has sexually abused a client

Privacy of Personal Information and Accessibility Service Policy:

I understand that Miriam Klaczkowski will collect some personal information about me. I understand that I have the right to review and the right to a copy of my personal information, barring a few rare exceptions. I understand that clinical records will be kept for 10 years.

Consultation:

In conformance with ethical guidelines and to assume the highest quality care, I may occasionally discuss your treatment with other licensed mental health professionals but your anonymity will be maintained whenever possible. The professionals consulted are also legally bound to keep the content of our consultations confidential.

In Case of an Emergency:

Emergency services are not available. In the case of an emergency, clients should dial 911, contact their Family Practitioner, or go to the Emergency Department of any hospital.

Informed Consent

I have read and understood the information presented in this document, and hereby consent to psychotherapy.

Signature of Client: _____

Contact Name: _____

Patient's Date of Birth: _____

Address: _____

Contact e-mail: _____

Telephone number: _____