SHEREL GRIFFITHS Therapy & Mediation Services
sherelgriffithstherapy@gmail.com
www.sherelgriffithstherapy.com
(514) 716-7208

Therapeutic Contract

Welcome to S.G. Therapy & Mediation Services. This document contains information as to who I am, clinical services and policies. Please read it carefully, make notes, and if needed ask for clarifications. Signed document will represent our therapeutic agreement.

Credentials and Professional Memberships:
I hold Master of Social Work (2006), Master of Science (Applied) in Couple and Family Therapy (2020) degrees from McGill University. I am a Licensed Clinical Social Worker (LCSW), Couple and Family Therapist (CFT) governed by the OTSTCFQ[1] licensed board. Registered psychotherapist permit with the OPQ[2].

Disclosure Statement:
As an inclusive and equity Couple and Family Therapist, I work with young adults (18+), individuals, couples of diverse ethno-cultural and identity groups experiencing emotional and interpersonal issues. From an affirmative and collaborative therapeutic partnership, I adopt a trauma-focused resilience integrative approach in helping you to improve and reauthor your relational difficulties. Through safe holding space, I vow to be your ally as you embark on the challenging and courageous process of self-discovery and lasting changes. The benefits of psychotherapy are rewarding, but its effectiveness entails active engagement. Improvements may not be generalizable.

Psychological Services:
The initial assessment will take place over the course of 1-3 sessions. Feedback will be provided. If therapy is to be pursued, treatment plan with personalized therapeutic goals will be established. If assessment request cannot be accommodated and if needed, you will be referred to the appropriate resources. In order to develop an effective structured treatment relationship in which changes can be actively tracked, weekly sessions are recommended for the first 8 weeks of therapy. Following that point, frequency (weekly, bi-weekly, monthly) to be discussed and reviewed. We will periodically review treatment goals and you may terminate therapy at any time.

Professional fees and policy:
Scheduled appointments are 60 minutes duration.
The hourly rate for individual therapy is: $130.00.
Hourly rate for couple therapy is: $160.00.
Payments are due before or at the end of each sessions and can be made by interac e-transfer. Receipts provided for third-party insurer reimbursement. Accepts employee assistance program (EAP) referrals. Fees will be adjusted after one year based on the cost of living.
There is a 48 hours cancellation policy. Administrative fee corresponding to the full hourly rate will be billed for late cancellations and missed appointments outside of the 48 hours policy. I reserve the right to terminate treatment for repetitive missed or cancelled appointments.

Confidentiality:
Psychotherapy services are regulated and bound by the ethical codes of confidentiality. Therapeutic notes, reports, evaluations, and any other identifying information acquired throughout therapy are securely preserved. Information pertaining to each individual client cannot be released or discussed to and with third parties without your written or verbal consent. Exceptions to confidentiality may include, but are not limited to the following:

- Information requested by the court of law.
- Threats or danger to self.
- Threats or homicidal harm to others.
- Disclosure of all forms of child abuse and neglect (emotional/physical/sexual).
- Disclosure of elder abuse.

As part of ongoing consultation, your case may be discussed with external supervisor or consult with colleagues. Identifying information will not be released without your informed consent.

At an administrative cost of $35.00, you may formally request copy of your file, in which you will only have access to the portion of therapy that you attended.

Consent to treatment:
I have read, understood and taken note of the above information. I agree to abide by the terms and conditions of this therapeutic contract and I freely consent to psychotherapy services.

Date of signatures: _____

Patient Name: _____ Signature: _____
Patient Name: _____ Signature: _____

Name of Therapist: _____
Titles: _____
Signature: _____

1 Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec

2 Ordre des psychologues du Québec