CONSENT FORM

Date: _____

Client Information:

Name(s):_____

D.O.B.(s):_____ Age (s):_____

☐ Telephone: _(____)_____

☐ Telephone: _(____)_____

Please check preferred number for voicemail messages.

Address: _____

Referred by: _____

CANCELLATION POLICY:

Appointments must be cancelled no less than <u>2 business days</u> to the scheduled session, otherwise the usual charge applies.

Consent:
I acknowledge entering into treatment with Dr. Alina Wydra.

Confidentiality:
Dr. Wydra will not give any information about me without my written permission, which would outline the nature of the information to be released, whom the information is to be released to, and for what period of time the release is valid. Under certain circumstances, however, Dr. Wydra is required by law to report concerns:

1. If you threaten bodily harm to yourself or another individual, or Dr. Wydra believes this is likely to happen.
2. If Dr. Wydra has reason to believe that a child needs protection or has been, or is likely to be, physically harmed, sexually abused, or sexually exploited by you or another person.
3. If a subpoena is issued to Dr. Wydra by the Court, she is compelled by law to release all information obtained during contact with her.

Sessional Fees:
I agree to pay $210.00 per 50 minute session at the time of service. This amount is payable by cheque or cash.

Insurance Companies and Extended Health Benefits:
Clients pay at time of service delivery and are responsible for claiming repayment from their insurance plan.

Termination of Therapy:
Generally this is mutually agreed upon by the therapist and client. However, you are free to stop at any time without obligation.

Agreement of Understanding:
I have read this information sheet, understand it, and agree to its terms.

_____ _____

Client's Signature Dr. Alina Wydra