



BRAVE

PSYCHOLOGICAL SERVICES LTD

CLIENT INFORMATION

DATE: _____ CLIENT NAME(S): _____

BIRTHDATE(S) (DD/MM/YY): _____ AGE(S): _____ SEX(S): _____

MAILING ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PHONE:(Preferred) _____ (Other) _____

EMAIL(S): _____

REFERRAL SOURCE: _____

PREVIOUS COUNSELLING: Yes No If "Yes" for what reason? _____

What was the outcome? No effect Helped a little Helped a lot

GENERAL HEALTH: Excellent Good Acceptable Poor

Under Doctor's care for any reason? _____

Doctor's Name: _____ Medical Conditions/diagnosis: _____

_____ Medications (Drug name & Dosage): _____

ADDITIONAL INFO: (anything that would be helpful for me to understand you better before working with you) _____

EMERGENCY CONTACT: _____ PHONE: _____

RESPONSIBLE PARTY INFORMATION *(For Minors/dependents only)*

GUARDIAN(S) NAMES: _____ MARITAL STATUS: _____

PHONE: _____ EMAIL: _____

E: info@bravepsych.com **T:** (403) 252-3316 **W:** www.bravepsych.com

6455 Macleod Trail S, #302 Calgary, AB T2H 0K9



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INFORMED CONSENT & POLICY STATEMENT

CONFIDENTIALITY: As part of your counseling service, I request permission for anonymous case consultations to occur for the purpose of case direction and formulation to better serve you in our counseling relationship. Your identifying information will not be disclosed during these consultations. The contents discussed within the counseling relationship will be kept confidential with the following exceptions:

1. If you give prior written permission to have it released.
2. If there is a concern about harm to self/others, I am bound to act in order to ensure safety.
3. If the abuse of a child is involved, by law, this must be reported.
4. If I am subpoenaed by court to release the file.

PAYMENT OF FEES: Payment for services is the client's responsibility (or parent/ guardian, if client is a dependent or minor). The charge for each session is \$165. Sessions are 50-60 minutes in length. Payment is to me made on the day of each session unless other arrangements have been made between the client and the therapist. Please note that there is a \$25 fee for all returned cheques.

APPOINTMENTS: Appointments can be made through Active Back to Health Centre or with me directly. You agree that if you fail to cancel your appointment within 24 hours of your appointment time that you may be billed for the full fee at the discretion of the therapist. Please understand that insurance companies do not cover missed appointments.

If you agree to the above parameters of confidentiality, payment of fees and appointment bookings, your signature below is required.

Client Name(s) (Please Print)

Responsible Party Name(s) (Please Print)(*as required*)

Signature(s)

Responsible Party Signature(s) (*as required*)

Date

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