whole soul healing

BODY, MIND, AND SPIRIT

CLIENT CONTACT INFORMATION

Name: Date of Birth:
Phone: Email:
Home address: Postal Code:

CONSENT FOR TREATMENT

Welcome to Whole Soul Healing. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

My name is Rachel Cadrin. I have a Masters in counselling specializing in art therapy. I provide, individual, couples, and group counselling. My theoretical orientations are best described as humanistic and neuroscience. In my practice I employ a range of theories and techniques tailored to your individual situation. These include Cognitive Behavioural (CBT), Solution-focused, Mindfulness-based psychology, Family Systems Therapy, Art therapy, and Trauma-informed therapy.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular goals you hope to achieve. There are many different methods I may use to support you in attaining your goals. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. That being said psychotherapy has been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Please note there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.
I, hereby consent to receiving psychological treatment with the following understandings:

CONFIDENTIALITY

I understand that all information shared with my therapist is confidential and no information

will be released without my written authorization. I understand that any personal information that is collected is done so under the Privacy Protection Act and is gathered by Whole Soul Healing solely for the purposes of collecting fees, mailing forms, and arranging appointments. This information will not be released to other third parties or used for any other purpose than those outlined within this document.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Verbal consent for limited release of information may be necessary in special circumstances which will be discussed and attained prior to any action taken with my personal information. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

1. When there is risk of imminent danger to myself or to another person, my therapist is ethically and legally bound to take necessary steps to prevent such danger. This may include contacting relevant authorities even if I do not wish my therapist to do so.

2. When there is a reasonable suspicion that a child or elder or any vulnerable person is being sexually, physically or emotionally/psychologically abused or neglected or is at risk of such abuse, my therapist is legally required to take steps to protect the person, and to inform the proper authorities.

3. All other requests for my personal information to be either released or obtained by my therapist or other professionals (e.g., my family physician, lawyers, etc.) will be discussed as they arise and will require my written permission to comply, unless ordered by court.

4. In case I have elected to see my therapist out of multiple offices, I understand that this requires the physical transfer of my file, which may jeopardize my confidentiality (i.e. In case of a vehicle collision or theft).

THERAPY AGREEMENT

I understand that I am eligible to receive evidence-based treatment in the form of individual/group/family therapy. The type and extent of service that I will receive will be collaboratively determined thorough discussion with me.

I understand that I am free to discontinue these services at any time without penalty or prejudice (with the exception of late cancellations/no shows as identified below) and that I am encouraged to discuss either a change in therapist, approach, or a referral to another professional with my therapist to ensure that I receive the best care possible.

I understand that this consent will remain in effect until such a time as I withdraw it via written consent or discontinue services with my therapist by informing them of my intent to do so.

ATTENDANCE

Individual therapy sessions are 50 minutes in duration. Session frequency can vary over the treatment period, depending on the specific therapy goal and the progression of treatment. I agree to inform my therapist 24 hours prior to our appointment time if I need to cancel or change an appointment time. I understand that unexcused no shows or late cancellations will be automatically billed/charged at 50% of the total cost of the session booked.

FINANCIAL AGREEMENT

My hourly fee is $. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected

to pay for any professional time I spend on your legal matter, even if the request comes from another party.

I hereby agree to pay all fees relating to services received at Whole Soul Healing as well as any third party collection and legal costs associated with any recovery of amount outstanding should they occur. I acknowledge that my session fee is $ per one hour of face-to-face therapy and telephone consultations (excluding initial telephone, in-take, or scheduling) unless covered or otherwise specified through EAP or other contractual agreements in place. Other billable services, such as report writing, professional letters, form completion, and review of written records from other specialists are billed at the same rate.

I understand that a retainer amount may be collected to hold an appointment or prepare for an assessment and that additional charges will be added to that retainer to reach previously discussed or agreed upon fee for service and fees shall never exceed the agreed upon amount. Payment is required at the end of each appointment and I will receive a receipt upon payment. I acknowledge that, should I be unable to remit payment for a session, it will not be possible to book another session until such a time as I have paid all outstanding fees. All fees are tax deductible. Whole Soul Healing accepts VISA, MASTERCARD, or cash for services rendered.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by the insurance contract].

RISKS AND BENEFITS

I understand that while psychotherapy may provide significant benefits based on empirical evidence, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recollection of troubling memories. I also understand that choosing not to engage in therapeutic treatment may also result in greater discomfort or escalating risks. It has been explained to me that my feedback and communication about the therapy process and impact is crucial in reducing my risk for harm, and my therapist has encouraged me to communicate any concerns or discomforts with them as soon as is feasibly possible in my treatment. I also acknowledge that therapy is most effective when I am comfortable with my therapist and so, should I not feel comfortable or connected to this therapist I will either request a transfer to another individual or make my concerns known in order to best facilitate care for myself.

ARTWORK STORAGE

Artwork will be photographed for the purpose of record keeping. All physical artwork will be destroyed and disposed of at the end of each session (unless the work is on-going over more than one session then the work will be safely stored by Whole Soul Healing).

CONTACTING ME

I am often not immediately available by phone as I am unable to answer my phone while I am with clients. I will return your message within 24 hours of receiving and can be reached at 403-370-8670. I am available by email rachel@wholesoulhealing.com and I will respond to emails within 24 hours. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

RIGHTS AND RESPONSIBILITIES

I have a right to be treated with respect, dignity, and without discrimination regardless my age, gender, mental and physical status, sexual orientation, race, belief system or ethnic background. I can expect from my therapist to make their best effort to conduct therapy as competently as possible. I have a right to ask questions at any time, be informed by my therapist as to their qualifications, areas of specializations and limitations, and the code of ethics which they follow. I have a right to be advised as to the limits of therapeutic service, discuss my treatment with others (including getting a second opinion), and have been informed of the College of Alberta Psychologists' grievance procedures so that I may file a formal complaint when I am not able to resolve my concerns with my therapist. I understand that I may stop treatment at any time. I understand that I have a right to view my file notes at any time and to know what is being recorded about me.

I understand that I am responsible for setting therapeutic goals for my treatment and review them as required. I will cooperate with my therapist in evaluating the treatment process and work toward achieving my self-identified goals.

Client Name:

Participant signature:

Date:

Witness Name:

Signature:

Date: