ESSENCE
WELLNESS CLINIC

PSYCHOLOGY INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____(Cell) _____

Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

Patient Health History:

Please list your **health concerns** (from major to minor):

1. _____
2. _____
3. _____

Please list all **accidents**, **surgeries** or **hospitalizations** and the **year** they occurred:

_____ _____

_____ _____

_____ _____

Please list any **medications** and **supplements** you are currently taking and **dosage**:

_____

_____

_____

Are you currently seeing any other **alternative health care** professionals? (Chiro, Massage, etc)

_____

_____

_____

Family Doctor's name: _____

Clinic Name/Area: _____ Phone Number: _____

Consent for Treatment with Essence Wellness Clinic

I, the Client, hereby consent to receiving psychological treatment with the following understandings:

Limits of 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 Health Professions Act (HPA), the Personal Information Protection Act (PIPA) and where applicable, also the Freedom of Information and Privacy Act (FOIP), and is gathered by Essence Wellness Clinic, solely for the purposes of collecting fees, mailing forms, arranging appointments, facilitating my treatment, and managing my treatment records. My personal information will not be used for any purpose other than those outlined in this Consent for Treatment nor be released without my consent except as required and permitted by law. 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 exceptions to this confidentiality which include the following: 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. When there is a reasonable suspicion that a child, elder, or any vulnerable person is being sexually, physically or emotionally/psychologically abused, 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. When a client reports a psychological condition, that in whole or in part, was caused by something that happened at work and psychological symptoms have caused them to be off work for more than one day, and/or caused or is likely to cause them to be unable to perform their regular working duties, the therapist is legally bound to file a WCB report. 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. 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 the case of a vehicle collision or theft). That non-face-to-face work (i.e. phone) has certain confidentiality risks associated with it as the clinic cannot control the client's technology access, security provisions, or privacy limitations.

Risks and Benefits of Psychotherapy: 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. I also acknowledge that I have been informed here that my feedback and communication about the therapy process and impact is crucial in reducing my risk for harm, and that I am encouraged to communicate any concerns or discomforts with my therapist as soon as 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.

Client's Rights and Responsibilities in Therapy: I understand that I have a right to ask questions at any time as well as be informed by my therapist of their qualifications, areas of specializations and limitations, and the code of ethics which they follow. I have a right to consult with my therapists on the appropriate type of evidence-based treatment I may receive, be advised as to the limits of therapeutic service, and discuss my treatment with others (including getting a second opinion). I also have a right, should I see fit, to request for a change in therapist or approach, or be referred to another professional to ensure that I receive the best care possible. I understand that I may stop treatment at any time and 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. 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.

I understand and accept that I am responsible for the decision on how to handle issues identified in my interactions with my therapist as well as for implementing or integrating strategies, choices, actions and results arising out of or resulting from my interactions with my therapist. I further understand that my non-engagement in therapy or in therapeutic exercises, as introduced or recommended by my therapist, may delay or inhibit the achievement of my therapeutic goals. I also acknowledge that I have been informed here that if my therapist is a Registered Provisional Psychologist it means they have not fully completed licensure requirements through the College of Alberta Psychologists and is thus required to obtain supervision at least 1 hour per month with a Registered Psychologist. I further understand that my file information can be shared with their supervisor for the purpose of due diligence and consultation, but that my information will not be released outside of these individuals without my/our written consent. If a specific ethical or practice breach, in accordance with College of Alberta Psychologists' Code of Conduct is unaddressed, I may bring the matter to the College of Alberta Psychologists.

Telephone Therapy Participation in Telephone Therapy Sessions: I understand that I have the option to participate in telephone therapy with my therapist, when and where appropriate to do so. Should I choose to participate in telephone therapy sessions, I will do so with following understandings: Service Limitations and Service Options: I understand and accept the following: My personal information will not be used for any purpose other than those outlined in this Consent for Treatment nor be released without my consent except as required and permitted by law. Phone therapy sessions are not intended to replace the more optimal in-person sessions, but they are utilized upon my request, when in-person sessions are not convenient or possible. There is a potential for misunderstandings when visual cues are absent and/or limited in online communications. As such, either my therapist or I may need to seek clarification when ambiguities or questions of misinterpretations surface. Certain therapeutic interventions may not be available through telephone means or may have to be modified in order for it to work online or over the phone. In order to provide me with the best possible service, my therapist and I will need to routinely review the appropriateness of continuing my therapy over the phone, taking my best interest into consideration. My therapist or I reserve the right to discontinue my therapy over the phone and transfer me to in-person or other means of service should they or I conclude that I would receive greater benefit from in-person services or other means of service. As well, my therapist will, in consultation with me, make a referral for me to another source of mental health care if my therapist is unable to provide adequate or needed services to me. In the event of an emergency, I can call 911, go to the nearest hospital, or call the Distress Line at 403-266-4357.

Technology Limitations: While Essence will make every reasonable effort to implement technical security measures to reduce the risk of a confidentiality breach on its end, I recognize and accept the risk that no phone-based communication can be guaranteed to be 100% secure or confidential, and that risks such as internet participation being discovered by others. I accept that I may be required to provide proof of my identity or other identifiers in order for Essence to ensure that my information and service sessions are adequately protected. I also understand and accept that technical difficulties or complications may occur at any stage and part of my telephone therapy sessions. The client will plan ahead to minimize distractions (e.g. use a quiet room that I can be uninterrupted, not answering calls or text while in session, use headphones to increase privacy if necessary).

I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost if I fail to give less than 24 hours notice for cancellations. I will be responsible to pay that charge before I can re-book.**

Signature: _____ Date: _____