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Health Consent Form

I would like your informed consent for the services I am going to provide. First though, I want you to understand the services I hope to provide to you, the cost involved, and what I do with the personal information I obtain about you. If you have questions about any of this, please ask.

Nature of Services
I provide psychological treatment or psychotherapy. In order to provide you with the best service possible, I'll use the first one or two interviews to collect the information I need to understand your issues and concerns, and then together we'll discuss a treatment direction, plan and goals. You have the right to ask for information about your treatment plan and progress at any time.

Fees

If you're paying for your sessions . . .
Psychologist and Psychological Associate fees are not covered by OHIP. Some private extended health-care plans do cover part or all of the fee. My fee, as of February 1st, 2020 is $175.00 per session. On June 1st 2024 this will increase to $180.00. This fee covers appointments, brief letters, notes and phone check-ins as well as consultations with other health care providers/ professionals as needed. In other words, you are only charged for the time we are in direct contact during appointments. Lawyers, insurance providers for example will be charged my hourly rate for reports, forms, file reproduction as appropriate. Each session is 50- 60 minutes in length. Phone appointments and video appointments are billed at the hourly rate. Payment is requested at the end of each session and you may pay by e-transfer or credit card. If you choose to pay by e-transfer please include the date of the session in the comments and be aware that your name will appear as a transfer received by my bank. If you choose to pay by credit card, please know that I do not store your credit card information electronically anywhere.

Cancellations

Please put the date of our next appointment in your calendar. While I do send a confirmation of appointment reminder, it is a courtesy service. Life happens, if you need to reschedule or cancel an appointment, I would appreciate **24 hours' notice** in order that I may give that appointment to someone on the cancellation list. If you need to cancel on the same day of your appointment I charge a **$40 cancellation fee**. There are of course exceptions to this policy as some things cannot be anticipated. If you **are late** for your appointment, you will still be charged the full rate for the scheduled appointment.

Insurance

I do not submit to insurance companies on your behalf. I am able to provide you with a receipt that you can submit to your benefit plan as appropriate.

If WSIB or your auto insurance company is paying . . .
I will bill WSIB or your auto insurance company directly for all appointments that you attend. But please note that those agencies do not cover missed appointments or late cancellations. In other words, if you miss an appointment or cancel an appointment with less than 24 hours' notice, I will have to charge **you** for the session.

Confidentiality

Any information that you disclose to me is confidential. I will not share any part of it with others unless you provide me with written or occasionally verbal consent. **But there are some exceptions to this policy:**

- Should I have concern that a child has been or is at risk of abuse, I am obligated by law to contact Family and Children's Services (CAS)
- Should I have concerns that you are at risk for suicide or that you seriously threaten the safety of others, I am obligated to disclose this information to those who would help to ensure your safety
- Should I have a concern that a senior is being or at risk of being abused in a nursing home, I am obligated by law to report this
- Should reports of our work be subpoenaed by a court of law, I am required to release the records to the court
- Should you provide me with information indicating you have been the victim of sexual abuse/ inappropriate touch by a health-care provider who is a member of a regulated profession (e.g. Family Physician, Specialist or Psychologist etc…), I am obligated to report the health-care provider's name to his/her College if this has not already been done. I will not reveal your name unless I receive your written permission to do so

If I deem it to be in your best interests, I may consult with other mental-health professionals.

Personal Information
I will collect some personal information about you, such as your telephone number(s) and address in addition to information about the issue(s) you hope to address. I will protect the privacy of all your information as indicated in my Privacy Statement.

Consent

I have reviewed the policies described in this form, as well as Ms. Colavecchia's Privacy Statement. I have been given a chance to ask any questions I have about Ms. Colavecchia's policies concerning services, fees, confidentiality, and the use of my personal information, and my questions have been answered to my satisfaction. My signature indicates that I have agreed to the provision of services by Ms. Colavecchia and that I have received copies of this form (should I request it) and the Privacy Statement for my records.

Signature: _____ Date: _____

Printed name: _____

Revised January 2024