Marsh-Knickle & Associates

1278 Bedford Highway, Bedford, NS, B4A 1C7 **Tel: 902-832-0830 Fax: 902-404-3963**
mkpsych.com **marshknickle@eastlink.ca**

INFORMED CONSENT

I, _____, of_____
(Name) *(Address)*

hereby consent to participating in counseling sessions and I understand and agree that:

1. Participation carries some risks, including but not limited to changes in mood and behavior, which may also have an impact on my relationships and/or on my work and daily tasks.

2. What I say during counselling sessions will be held in strict confidence and will not be divulged to anyone without my express written consent, with the exceptions listed below:

   a. Confidential material may have to be divulged if subpoenaed by the courts, requested by WCB, or if I am deemed to be at risk of harm to myself or others, or if there is an imminent or ongoing risk of child or elder abuse.

   b. The NS Board of Examiners in Psychology (NSBEP) has the right to audit a psychologist's files if they perceive a need to protect the public.

   c. Some aspects of confidentiality may have to be breached if it is deemed necessary to secure payment for delinquent accounts, through a collections agent or the courts.

   d. My psychologist will seek my express written authorization to communicate with third parties, including my other health care professionals (i.e. family doctor). These health professionals may be entitled by law to share this information with other health professionals, not expressly authorized by me. In these cases, my psychologist has no control over such sharing of information and cannot be held responsible for same.

   e. To maintain a level of professional integrity, psychologists are required to consult with other psychologists on an ongoing basis. Every effort is made to ensure client confidentiality.

   f. For psychologists on the candidate register, digital audio recordings of counselling sessions may be made. These recordings may only be shared with the psychologist's NSBEP supervisor and are made with the express purpose of ensuring and maintaining best practices in client care.

3. I will be referred elsewhere if my case involves a lawsuit. _____
   *** (Client to initial) ***

4. Client cannot record session without therapist permission. _____
   *** (Client to initial) ***

FEES:

The therapy hour allows for 50 minutes with the Psychologist and 10 minutes reserved for file review and notations. Fees for this service, as well as for consultations, reports, and letter writing, are $190 per hour. Payment for therapy is due prior to the session. Receipts for services of Registered Psychologists and Psychologists on the Candidate Register are income tax deductible as health-care expenses. **Please Note:** If the outstanding payment is not paid within 30 days we have the right to forward to a collections agent.

MISSED APPOINTMENTS, INSUFFICIENT CANCELLATION OR RESCHEDULING NOTICE:

As a courtesy to clients on our waiting list and to your Psychologist, our policy concerning appointments missed or rescheduled without sufficient notice is adhered to without exception. In signing this consent form, you are agreeing to the terms outlined below. If you require clarification of any point, please discuss it with your Psychologist before signing.

A booked appointment is time that has been reserved for your exclusive use. This time remains your financial responsibility unless you release it for use by someone else by providing **at least 24-hours' notice of cancellation/rescheduling**. **Monday appointments must be cancelled/rescheduled by Friday at 12noon. Appointments scheduled on the first day following a holiday must be cancelled/rescheduled by 12noon on the last business day before the holiday. Voicemail or email messages left after business hours or on weekends or holidays do NOT count as sufficient notice and will remain your financial responsibility. 48 hours' notice is required for extended appointments (appointments scheduled for 2 hours or longer).**

The cost for time missed or cancelled/rescheduled without sufficient notice rests with you. In the case of illness or inclement weather, a telephone session can be arranged for you.

Fees for missed appointments must be paid in full to retain any further appointments in our schedule. The fee for missed appointments is the same as for appointments attended.

Appointments must be cancelled/rescheduled by phone/e-mail during business hours. Receipts for missed appointments will indicate "Missed Appointment" and may not be covered by insurers. To note them as otherwise could defraud third party payers.

LATE ARRIVALS AND EARLY DEPARTURES:

Unfortunately, time lost through late arrivals or early departures cannot be made up. Please call our office if you are going to be late, and your Psychologist will wait for you to begin your session.

Payment Authorization:

I agree that fees will be charged to my VISA or MASTERCARD account for appointments missed or cancelled without sufficient notice, as described above, and I hereby authorize any such charges. This authorization guarantees that my future appointments will be reserved for me. *

_____ _____ _____

(Credit Card Number) *(Expiry Date)* *(CVD #)*

*** I understand that fees for appointments missed or cancelled without sufficient notice, as described above, will be paid immediately. I realize that without immediate payment, appointments already scheduled for me will be cancelled and that my account will be forwarded to a collections agent if it remains unpaid after 30 days. ***

I have read, understood, and agree to the terms noted above:

_____ _____ _____

(Client Name) *(Client Signature)* *(Date)*

_____ _____

(Print Parents Name/Guardian) *(Print Parents Name / Guardian*

_____ _____

(Parent / Guardian Signature) *(Parent / Guardian Signature)*