Marsh-Knickle & Associates

1278 Bedford Hwy, Bedford, NS B4A 1C7 Tel: (902) 488-5975 Fax: (902) 404-3963

DESCRIPTION OF SERVICES

GOALS & OUTCOMES

Generally, the therapy provided by a therapist is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, or behaviors. You determine the nature and amount of change you wish to make.

BENEFITS & RISKS

Most people experience improvement or resolution to the concerns that brought them to therapy. Of course there are no guarantees and there are some risks. For example, therapy could open up new levels of awareness that may cause pain and anxiety.

CONFIDENTIALITY

We understand that the information you share in therapy is of a personal nature, and that you would want it to remain private. Confidentiality will be maintained unless you give us specific, written permission to share information with another person or agency. However, we are required by law to disclose confidential information if there is reason to believe that a child or elderly person is being, or is at risk of being, abused or neglected, or that you may be in danger of harming yourself or others. However, if you have been sent for an assessment and/or counseling by a third party (for example, the courts, Workers Compensation), we may be required to release information to that third party. On rare occasions, the courts may order us to release therapy records. Also under rare circumstances the NSBEP has the right to audit files if they perceive a need to protect the public.

LEGAL: If your case involves a legal matter you will be referred outside of Marsh-Knickle Psychological Services Inc.___

PAYMENT FOR SERVICES

Unless otherwise stated on this form, our fee for therapist services is **$150.00** per 50-minute session, and you, the client, are responsible to make payment to your therapist at the end of each session. Cash, cheque, debit card, MasterCard and Visa are accepted. A receipt will be issued to you. Our fees qualify as medical expenses for income tax purposes. Some extended health care insurance plans may reimburse you for part or all of our fees. It is your responsibility to determine what your coverage is.

CANCELLATION OF APPOINTMENTS

As a courtesy to your therapist, please notify us **24 hours** before your appointment if you cannot keep it. (Please call by Friday noon to cancel Monday appointments.) Except in emergencies, we will bill you at the rate shown for sessions missed without 24 hours' notice.

Credit Card # _____ *Expiry Date* _____

PLEASE NOTE: All outstanding fees exceeding 30 days from scheduled service date will be forwarded to a collection agency. Also, note that all returned NSF cheques will be billed an additional $25.00

PROBLEMS WITH THERAPY

You have the right to be treated with respect and dignity in a safe environment. If you have any concerns about the services you receive, or if you feel at any time that the services you are receiving are not helpful, please talk with your therapist about your concerns. Referrals to other psychologists can be provided. Please note that the client has the right to resend services at any time.

OTHER AREAS OF DISCUSSION

We encourage you to ask questions at any time about any aspect of our services for example:

- What is the background of your therapist, and what does he/she feel most qualified to treat?
- What methods does your therapist intend to use to help you, and how many sessions may be needed?
- What alternative forms of treatment may be available to you? (e.g., support groups, medical treatment)

- *I,*_____ *have read the above information and understand that I am encouraged to ask questions and give input regarding the therapy process at any time. If there is anything in this form that I do not understand, it is my responsibility to ask for clarification. I have received a copy of this form.*
- *I understand that payment arrangements are as follows:*
- *Person/agency responsible for payment* ☐ *Client* ☐ *3rd Party*_____
- *Fee per 50 minute session: $*_____ *Number of sessions covered by 3rd party:*_____
- *My therapist's name is:* ☐*Lauren Marsh-Knickle, M.Sc. Registered Psychologist Cell: 209-3908*
  ☐ *Kelly Brushett, M.Sc. RMFT Marriage and Family Therapist Cell: 488-5975*

_____ _____ _____ _____

Client *Date* *Parent/Guardian* *Date*

_____ _____

Witness *Date*