**Therapist Information Form**

**Contact Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Skype name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confidential Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preference for contact: Phone \_\_\_\_ Text \_\_\_\_ Email \_\_\_\_\_**

**Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Background Info**

**Relationship status:**

**Occupation:**

**Current medical treatments/medications:**

**Drug and Alcohol history:**

**Other relevant information, events in your life:**

**Any history of suicidal thoughts or actions, (if so, when):**

**Healthy Connections Psychotherapy**

**Lee-Ann Leslie-Augustine, Registered Psychotherapist (R.P)**

**BA, DipTIRP**

Welcome to my practice. I offer relational psychotherapy for adult individuals and couples. I am a registered psychotherapist with the college of Registered Psychotherapists of Ontario (CRPO). Together we can create a therapeutic relationship and collaborate to create therapy goals that suit your individual needs. With this in mind there are rights, responsibilities and information that need to be shared and agreed upon in order to create safe boundaries for our work together.

Sessions are 50mins unless an extended session is requested. Your fee is to be paid by the end of your session via cash, cheque or email transfer within 24hrs of your appointment. A receipt can be issued upon your request. If using insurance coverage payment must be made upfront and a receipt can be submitted to your insurance company. Please check that you are covered for “psychotherapy” issued by a registered psychotherapist. If you are not covered, psychotherapy services can be used as a non-reimbursed medical expense on your tax return.

**Confidentiality**

Psychotherapy is a confidential service. Your therapist will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware.

*Duty to Warn and Protect*

• When a client discloses intentions or a plan to harm another person the therapist is required to warn the intended victim and report to the legal authorities.

• In the case that the client discloses a plan to commit suicide the therapist is legally required to inform the authorities and make reasonable attempts to contact the family.

*Abuse of Children/Vulnerable Adults*

• If the client states or suggests that he/she is abusing a child/vulnerable adult, has recently abused a child/vulnerable adult or a child/vulnerable adult is in danger of abuse, the therapist is required to report to the appropriate social services or legal authorities.

*Prenatal Exposure to Controlled Substances*

• The mental health professional is required to report admitted exposure to controlled substances that are potentially harmful to the baby.

*Minors/Guardianship*

• Parents or legal guardians of non-emancipated clients have the right to access client records

*Insurance Providers (when applicable)*

• When Applicable, insurance companies and other third party payers may require information regarding services to clients. This may include, but not limited to: types of service, dates/times of services, diagnosis, treatment plans, description of impairment, progress of therapy, case notes.

Your therapist may consult with a supervisor or other professional therapist in order to give you the best service. In the event that your therapist consults with another counselor, no identifying information such as your name would be released.

**Confidentiality and Technology**

Some clients may choose to use technology in relation to their therapy sessions. This includes but is not limited to online therapy or communication via Skype, telephone, email, text or chat. Due to the nature of online therapy, though it is not likely, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your therapist will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in therapy sessions.

**Record Keeping**

Your therapist keeps records of your counseling sessions with treatment plan/goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom.

I understand/agree to the limits of confidentiality X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation policy**

* Your commitment to our sessions is important. If you cannot make your appointment ***24hrs notice is required***. This will allow for the appointment time to be filled and you will avoid being charged a cancellation fee. The cancellation fee will be half the session fee.

I understand/agree to the cancellation policy

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions or concerns regarding the parameters of our work together I encourage open communication.

**Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notes:**

**Treatment Plan:**