ABMA COUNSELLING SERVICES
Consent Form

I. Clinical Services Offered
Psychotherapist, Psychologist and Social Work services for adults, adolescents and children.

II. Assurance of Confidentiality
Confidentiality is respected at all times. No information will be communicated, directly or indirectly, to a third party without your informed and written consent. Exceptions to confidentiality include our legal and/or ethical obligations to:

- Inform a potential victim of violence of a client's intention to harm.
- Inform an appropriate family member, health care professional, or police if necessary of a client's intention to end his or her life.
- Release a client's file if there is a court order to do so.
- Inform Family and Children's Services if there is suspicion of a child being at risk or in need of protection due to neglect, or physical, sexual, or emotional abuse.
- Report a health professional who has sexually abused a client.

Abma Counselling is in full compliance with the Personal Health Information Protection Act (PHIPA) and the Personal Information Protection & Electronic Documents Act (PIPEDA).

III. Fees
Fees have been chosen according to the fees set by each therapist's respective College. Before your first appointment, carefully check with your insurance provider to determine the type, degree, amount, and duration of counselling coverage you have under your plan (e.g. Psychologist, Psychotherapist, Social Worker). Abma Counselling is not responsible if your insurer denies your claim. Payment for services is due upon the end of each session and a receipt will be issued when payment is received. If payment is made via credit card, the client's card number and information will be held on file and used to process session fees.
The usual hourly rate also applies for any written reports and letters to third parties or legal testimony.

In order to maximize the effectiveness of therapy, clients should not cancel their appointment times except in the case of an emergency. Full session fees will be charged for missed or canceled appointments less than 24 hours in advance. If a client customarily pays by credit card, their account will be charged and a receipt issued for no shows or late cancelations.

IV. Consent
I have read and understood the information described above and hereby request to receive clinical services.

Client/Guardian Name: _____ Date: _____

Client/Guardian Name: _____ Date: _____

Therapist Name: _____ Date: _____

Thank you for completing this Consent Form.

1. ***Save this form to your computer by either:***
    a. ***Scrolling to the top of the form and choosing the download icon***  ***that appears on the top right of your browser window, or***
    b. ***Right-click and select 'Save As'.***
    c. ***Save Your Form as "(Your Name) Consent Form"***
2. ***Email the form as an attachment to info@abmacounselling.com.***
3. ***Questions about how to send this form? Text or call us at 905-321-0550.***