YOUR HEALTH

Wellness Centre

1158 Winston Churchill Blvd

Oakville, ON L6J 0A3

Counselling and Psychotherapy New Patient Form

Patient Information (please print clearly)

Name: _____ Date of Birth (mm/dd/yyyy): ____/____/____ Age: _____

Address: _____

City: _____Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____ (to receive appointment reminders)

☐ Add me to the email newsletter (Our newsletter covers events at the clinic and highlights informative articles written by our therapists. You can unsubscribe from the newsletter at any time.)

Occupation: _____ How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____

(Phone) _____

Fees: $120 per session

Payment

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Mastercard and Visa. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist.

In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours' notice will be charged in full, unless the appointment is rescheduled within 48 hours.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

I have read the YOUR HEALTH Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

Patient Signature: _____ Date: _____

Privacy Policy

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way.

We will also try to be an open and transparent as to how we handle personal information. Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the the Personal Health Information Protection Act (2004). No information will be realized to a third party at any time without your written authorization. You have the right to withdraw this consent at any time.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under Ontario College of Social Workers and Social Service Workers
- To process payments and collect unpaid accounts
- For consultation on an anonymous basis with a supervisor as per the Ontario College of Social Workers and Social Service Workers

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest. Please note your session notes and details about your counselling case will be stored in a separate locked cabinet. Information regarding counselling issues will only be shared with other staff at YOUR HEALTH with your written consent.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

There are situations where your personal information may be shared with or without your written or verbal consent. These situations are rare; however, the possibility does exist and we would like you to be aware of these circumstances. If there are other circumstances related to your situation we will review them with you.

1. If we become aware of any information related to abuse of a child or if a child is exposed to domestic violence, then we must report it to the proper authority.
2. If there is a concern you are at risk to harm yourself or to harm to someone else, we must alert the proper authority.
3. If we are subpoenaed to a court of law.
4. When disclosure is needed to receive a professional or legal opinion.
5. In defense against a complaint with the Ontario College of Social Workers and Social Services Workers or any other court action.

Email

You will be provided with an email address to contact your counsellor in the event that you need to cancel or reschedule. You may also contact reception for these purposes. Please be aware email is not considered to be secure and you are at risk for your confidentiality being breached. We will NOT discuss counselling issues over email. Please book a session if there is something you need to discuss related counselling issues. If you are experiencing a crisis and cannot reach your counsellor directly to schedule an appointment, please contact reception or go to your nearest hospital or emergency department. Your counsellor accepts no liability for any interference or damage to your computer system, software, data or information with your use of email.

Counselling Informed Consent

Counselling is not the same as talking to a friend or family member. It generally involves having specific goals that you would like to address during your course of treatment. The number of sessions required varies depending on the person and their situation. The benefits of therapy include reaching your desired goal, the development of new coping strategies and tools to deal with stressful life situations and a greater understanding of yourself and how different situations affect you. The risks of counselling include the arousal of powerful emotions and remembering unpleasant events in your life – however the goal of counselling is not to avoid these feelings. Please be aware that counselling cannot guarantee results for any given situation. Counselling also includes selected activities to be completed outside the counselling session and sessions should be attended regularly.

I intend this consent form to cover the entire course of treatment for my presenting issues. I understand that I am free to withdraw my consent and to discontinue participation in this treatment at any time.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive at YOUR HEALTH Wellness Center and hereby authorize and consent to treatment.

Dated this _____ day of _____, 20_____

Patient Name: (print) _____

(Signature) _____

Counsellor: (print) _____

(Signature) _____

Are you currently receiving healthcare?

If yes, where and from whom?

Medical Doctor? _____ Phone: _____

Naturopathic care? _____ Phone: _____

Chiropractic Care? _____ Phone: _____

Other Practitioner? _____ Phone: _____

Can we send a letter to your family physician informing him or her of the services you are receiving?

Yes_____ No _____

Relationship Status (please circle one)

Single Married Partnered Separated Divorced Widowed

If applicable, Partners name, age, years in relationship_____

Children (please note gender and age):_____

How would you describe your general state of health? Excellent Good Fair Poor

Please describe any current or past significant medical problems (including psychiatric – e.g. depression, anxiety, bipolar disorder, post-traumatic stress disorder, panic attacks, phobias, schizophrenia, subststance abuse):

_____

_____

_____

_____

_____

Please list any medications you are currently taking, including prescription and over the counter:

_____

_____

_____

_____

Are you currently experiencing problems with any of the following?

Eating Issues Sleeping Issues Pain Issues

Please explain _____

How much alcohol do you drink per day/week and what type_____

Do you smoke? Y/N _____ If yes, when did you start? _____

How many cigarettes do you smoke per day/week? _____

If you previously smoked, when did you quit? _____

How much caffeine do you drink per day/week (coffee, black tea, pop) and when do you drink it?

_____

Do you take any recreational drugs? What kind and how often? _____

Have you ever had previous psychological care or counselling? Yes/No (please circle)

If yes, please give details as to who you saw, when you were seen and the nature of difficulty at the time:

_____

_____

_____

_____

What is the nature of the concern that you wish to address in therapy? Feel free to use as much or as little detail as you would like.

In order for therapy to be effective, it is helpful to have a clear and specific goal. You may find it difficult to express this, but please make an initial effort. You will discuss this with your counsellor. Feel free to list more than one goal.