Kellye Woods, M.Ed., M.S.W., R.S.W.

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**PATHWAYS COUNSELLING INFORMED CONSENT**

The assessment process will identify therapeutic goals and will assist us in collaboratively deciding upon a treatment plan that best fits your needs. Counselling services are generally short-term in nature and will be focused on assisting you to learn ways of coping with physical, emotional, and mental distress.

***Appointments***

Office hours are Monday to Thursday, 9:00 am to 4:00pm.

***Insurance Coverage***

Counselling services are not covered by OHIP but can be partially covered by many extended health insurance plans. Coverage varies with each plan, so please verify with your provider their claim procedure, details required on receipts, and if a referral from your physician is required.

***Payment for Services and Fees (Ceridian Clients Exempt as EAP Provider Covers Payment)***

The fee for counselling services is $150.00 per session. The 60 minute initial assessment provides the opportunity to gather important information to establish goals and formulate a therapeutic treatment plan. Each counselling session thereafter will be 50 minutes in duration. The remaining 10 minutes of each follow up session hour are focused on session overview and planning for future sessions in order to provide you with optimal care.

Payment for services is due at the beginning of each session and can be done by cash, cheque, e-transfer, and major credit cards. If the chosen form of payment is an e-transfer, the transfer will need to be sent prior to the session commencing. A receipt will be provided when payment is received, which can be used for insurance or income tax claims, if applicable.

***Cancellations and Missed Appointments***

24 hours notice is required for all cancelled appointments. If sessions are cancelled with less than 24 hours notice, or if you do not attend a scheduled appointment, the cancellation fee will be half the session cost: $75.

If you arrive late for your scheduled session, you will be seen for the remainder of the session time and the time will not be extended.

***Confidentiality***

At no point is your personal information shared to a third party without your written, informed consent. However, exceptions to confidentiality include the legal obligation to:

* + Inform an appropriate resource person of a client’s intention to end his/her life.
  + Inform a potential victim of physical violence of a client’s intention to inflict harm.
  + Inform the Children’s Aid Society if a client discloses ongoing physical, emotional and/or sexual abuse or neglect of a child.
  + Release a client’s file if it is subpoenaed by a court of law.

To maintain your confidentiality, if we encounter each other in a public or private setting, no contact will be initiated. Any initiations will be left to you based upon your comfort level.

***Privacy Policy***

The nature of counselling services involves sharing personal information with your clinician, including demographic information.

This practice is run in compliance with the Federal privacy legislation about the collection, use, and disclosure of personal information, the steps taken to protect that information, and your right to review personal information. The necessary precautions have been taken to ensure the safety of your information, whether electronically or on paper. Specifically, in terms of handling electronic information, the following is ensured:

* any sensitive client information that is stored on computers, servers, or portable drives (e.g. USB keys) is encrypted
* client information is backed up and stored so it is not lost and is easily retrievable
* electronic communication tools (e.g. mobile phone, email, fax) are used in a manner that ensures confidentiality
* College and PHIPA standards are maintained

***Contact Information***

I may not always be available by telephone. Telephone messages can be left at any time and they will be returned at my earliest convenience. Email is to be used for scheduling issues only. Phone messages are checked during daytime hours. Should you have an emergency or crisis, and I am not immediately available, please call the Ottawa Distress Centre at (613) 238-3311, go to the nearest hospital with an emergency room, or call 911 if you are in danger.

***Request For Services***

My signature below indicates that:

* I have reviewed the information on this form and have been given the opportunity to ask questions which have been answered to my satisfaction.
* I agree to Kellye Woods, M. Ed., M.S.W., R.S.W., collecting, using, and disclosing personal information about me as described above and as set out in her privacy policy.
* I hereby give consent for counselling services with Kellye Woods, M.Ed., M.S.W., R.S.W

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Consent to Release and Exchange Information with Family Physician (Optional)***

My signature below indicates that:

* I consent to my clinician releasing and exchanging pertinent care related issues with my family physician as needed. This consent will be applicable for 6 months subsequent to the date of my signing and I am aware I can revoke this consent at any time.

Client Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_