restorative conversations

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Professional Service Agreement and Informed Consent

This document contains important information about professional services and practice polices. Please read this carefully and please discuss any questions you may have with me. When you sign this document you will attesting that we have provided you with this information and it will serve as an agreement between us.

Psychotherapy Services

The goal and intention of psychotherapy is to assist you in reaching your goals for a resolution to obstacles in leading a more fulfilled life. We will explore obstacles and strategies to creating change in the way you think, behave and interact. There are a variety of methods to achieve this and they will be tailored to your situations and goals. Through a deeper understanding of yourself, we will work to enhance your relationships.

Psychotherapy has benefits and risks. Risks may include experiencing emotional discomfort, sadness, guilt, anxiety or frustration as you discuss and reflect on aspects of your life. Psychotherapy has been shown to have benefits that may include enhanced relationships, improved physical health, reduction in stress and overall increased life satisfaction. However, there are no guarantees of what you may experience.

Our initial sessions will involve an assessment of your needs and goals. We value collaboration in this process because psychotherapy is an interactional, collaborative relationship and not something that is "done to you".

Professional Fees

Our fee is $180.00 per 50 minute clinical hour. Payment is expected at the time of service. Debit, Visa, Cash or Cheques are accepted for payment.

Some companies have extended health care insurance plans that provide full or partial coverage of psychological services. Insurance companies are not billed directly, but detailed invoices and receipts are provided so that you may seek additional coverage for your expenses. Families are encouraged to obtain information directly from their insurance companies regarding extent of coverage.

Should you need a letter or summary report, you will be charged at our professional rate for that service. It will be billed in 15 minute increments. A Consent to Release Information will need to be signed before any document regarding your care can leave our office.

Confidentiality

Your confidentiality is critical. We may not speak to anyone about our work without your written authorization. Should you wish us to communicate with someone else (e.g. your Family Physician, Psychiatrist) we will complete a Release of Information document). It is important for

you to know that there are some specific situations in which your confidential information may be disclosed to others without your informed, written consent. These include:

- Where there are reasonable and probable grounds to believe that your safety or the safety of another person is at risk.
- Where there are reasonable and probable grounds to believe that a child or vulnerable adult is in need of protection, or
- When information is subpoenaed by a court of law for the purposes of legal proceedings.

If you have been referred by a third party, the third party may have, as a condition of receiving services here, access to certain information about you. Information about you that is held by us may be subject to certain legislation (FOIPP or HIA).

Mental Health Professionals regularly seek consultation / clinical supervision from Colleagues. These consultations are bound by confidentiality. If a discussion occurs with a consulting psychiatrist, your Alberta Health and Wellness Card will be billed for that service (at no charge to you).

Contact Between Sessions / Emergencies

Since we do not answer phone calls during sessions, we may not be immediately available by phone. Voicemail is checked several times each day. Should an emergency arise you may alternatively call **The Distress Centre 24 hours 7 days per week (403 266 1605)** or proceed to Urgent Therapy @ Sheldon Chumir Health Centre (1213 - 4 Street, SW in Calgary 403 955 6200), or your nearest Emergency Department.

If discretion in returning a call is indicated, please specify this in your voicemail.

What You May Expect From Your Therapist

You will have their undivided attention during sessions. They do not take phone calls during sessions unless there is an unfolding emergency. In that situation, your therapist will inform you of this and we will still have our full appointment:

- We will be prompt for our appointments
- We will maintain confidentiality according to the guidelines outlined in this agreement
- We will offer you therapy services based on best practice guidelines
- We will create and maintain a therapeutic environment that is safe for us both and is conducive to the work of psychotherapy

We will abide by the ethical guidelines of our Professional College's

- The Alberta College of Social Workers and the ACSW Clinical Registry
- The College of Alberta Psychologists

What Is Expected From You

That you will arrive promptly for appointments. If you arrive late, the appointment will not be extended.

That if an appointment needs to be cancelled, 24 hour advance notice is required. If you cancel less than 24 hours in advance or fail to attend an appointment, you will be charged $180 for the late cancellation. This fee must be paid at the next scheduled session.

That you will use the timeframe between sessions for further reflection and work on your goals

That you will alert us to:

- changes in medications (if applicable)
- changes to your health
- changes to your contact information (address, phone)

Psychotherapy is a collaborative journey between a client and therapist. Our work is solely designed to assist you in enhancing your life and making changes in the ways you may relate to yourself and / or others.

Thank you for the opportunity to work with you. We honour and value your trust. Should questions arise during our work, always feel free to bring them to your session.

Your signature indicates you have read, understand and agree to these guidelines. It also indicates we have provided you with a copy of this document for personal reference.

I have read the above material and understand its provisions. I understand that the results of therapy vary from person to person and that achieving a positive outcome depends upon my effort as well as that of my therapist.

_____	_____	_____
Name (please print)	Client Signature	Date
_____	_____	_____
Therapist (please print)	Therapist Signature	Date

Consent to Use Email and Phone Communications

I hereby agree to sending and receiving from email communications as part of comprehensive treatment. I understand the risks of sending Personal Health Information (PHI) through email, with this agreement I am accepting these risks to my PHI. I accept that Restorative Conversations shall not be held responsible for any exposure of email communications at my home, my place of work, or through my mobile device, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Restorative Conversations if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Restorative Conversations in writing. With my signature, I believe that the benefits of using email communications for my healthcare outweigh the security risks.

Authorization for Messages:

I authorize that telephone messages regarding my appointment times may be left on my:
(please check yes or no for each item)

Home voicemail: ❑ Yes ❑ No Work voicemail: ❑ Yes ❑ No Cell voicemail: ❑ Yes ❑ No

_____

Signature authorizing phone and email communications Date

Email Address: _____