PATRICIA TURNER COUNSELLING AND CONSULTATION INC.

Dr. Patricia Turner, R.Psych.
Clinical Psychologist
Suite 622, 304 – 8 Avenue SW, Calgary, T2P 1C1
Tel (403) 700-1776 Fax (844)-202-3964

Psychological Services Agreement

The purpose of this document is to provide you with an outline of the services we have agreed upon, which is required prior to receiving the services of a Registered Psychologist.

Please read this form carefully before signing at the bottom.

This document outlines:
1. Confidentiality and limits on confidentiality
2. Informed consent to assessment and/or treatment
3. Fee disclosure
4. Consent to release information

1. CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

All communications with a treating psychologist and all records relating to the provision of psychological services are confidential and cannot be disclosed without the client's written consent. The law does, however, place certain limits on the confidential nature of psychological services.

Typically, these limits on confidentiality may arise if a psychologist perceives there is a risk of harm in situations that include the following:

Imminent danger to self or others
If a person presents an imminent danger to themselves or others, the law requires that steps be taken to prevent such harm, which can include releasing information about a person's psychological state.

Abuse of children
If a child is in need of protection from abuse or maltreatment, a report must be filed with the appropriate agency or authorities, which will also be documented in the clinical file. Please ask for additional information about the different reporting obligations that exist for the protection of children.

Abuse of vulnerable adults
If a vulnerable adult is abused or neglected, a report may be filed with the appropriate government agency, which will also be noted in the clinical file. Please ask for additional information about the different reporting obligations that exist for the protection of vulnerable adults.

In addition, confidentiality cannot be guaranteed under the following circumstances:

Court Orders
I may be served with a Court Order to appear as a fact or expert witness, or to release your records to the Courts or their representatives, if you are in trouble with the law or have matters involving potential litigation.

Third party payers
Individuals referred for assessment and/or treatment by a physician, psychiatrist, or agency such as an insurance company, can assume that the referring party may want to receive some type of report and/or evaluation.

Minors
A guardian may have the right to impose a limit on the right to confidentiality if you are a minor.

Coroner or medical examiner
I am required to provide necessary information if I am contacted by a coroner or medical examiner.

Email communication
I cannot guarantee confidentiality if I am contacted by email, or if I am asked to respond to an email message with a written response.

Internet networking opportunities
I am unable to accept invitations from clients to become part of their networks on forums such as LinkedIn.

2. INFORMED CONSENT TO ASSESSMENT AND/OR TREATMENT

Benefits
Examples of personal issues you may bring to therapy can include anxiety, depression, anger, grief, relationship concerns, and historic or ongoing abuse. Assessment is helpful in planning interventions, treatments, and support. Therapy can help you to gain new understandings about themselves, bring relief from many different problems, teach new ways of coping with and solving these problems, and increase quality of life in numerous ways.

Risks
In working to achieve these benefits, you may address issues or make changes that are experienced as distressing. The risks of therapy include, but are not limited to, feelings or circumstances becoming worse before they get better; changes in emotional states, perceptions or behaviors; and changes in occupational, social, or personal relationships.

Progress and effectiveness
To achieve the greatest progress in therapy, I will work to provide you with the best and most appropriate therapeutic interventions. You can facilitate this process by being active in the therapeutic process, maintaining your motivation, completing agreed upon assignments between sessions, and communicating openly and honestly.

The length and frequency of sessions, as well as the duration of treatment, can vary significantly from client to client, and can be discussed at the beginning and throughout the course of therapy.

Because success and/or satisfaction with therapy cannot be guaranteed, I ask that you advise me if you do not feel satisfied with your progress. We may be able to work through the issues, modify

treatment, or negotiate a new therapeutic contract. In some instances, this may mean making an appropriate referral, or even terminating therapy. You can choose to leave therapy at any time. However, leaving therapy is best accomplished in consultation during therapy so please discuss any issues as they arise with me directly.

Additional treatment
You are free at any time to pursue alternative options for treatment such as psychotropic medications, emergency services, self-help groups, and the services of other mental health professionals who may offer different training, techniques, specialties, and theoretical approaches. Generally, it is best to work with only one therapist at a time because interactions may occur that can deter from our work together, so I ask you to please let me know if you choose to participate in additional therapies.

Contact
I may be difficult to reach directly at times because I am often in session during the week and am not in my office on weekends. To speak with me, please leave a voicemail message with your full name and number on my confidential voicemail at 403.700.1776. I check for messages frequently and will return your call as promptly as possible.

Crises and Emergencies
If you feel an urgent need to reach me, please leave a voicemail message stating that the matter is urgent. If I am unable to call or see you as soon as needed, you may choose to contact an alternate source of support, including one of the following 24-hour crisis centres:

- Calgary Distress Line – 403.266.1605
- Eastside Family Centre and Westside Family Centre, Crisis Line – 403.299.9699
- Canadian Mental Health Association, Suicide Services – 403.297.1744
- Calgary Hospital Emergency Departments

3. FEE DISCLOSURE

Therapy sessions will last 50 minutes unless otherwise agreed upon. I can occasionally increase the length of a session after the session has started, on a case-by-case basis, if requested.

Fees
My fee is $240 for individual therapy for a 50-minute session. Payment is required at the end of each appointment using cash, cheque, debit, Visa or Mastercard. A fee of $40 will be applied to any N.S.F. cheques. Please let me know if you have made arrangements for the fee to be paid by an insurance company or another third party.

Consultation, report writing, letters, photocopies, and forms completed outside the therapy session will be billed in 15-minute increments at the rate of the service being provided.

Cancellation policy
The time of your scheduled appointment has been reserved for you. I ask that you give advance notice of at least two full business days if you need to cancel or reschedule an appointment. If you are unable to do so, you will be charged the full fee for the session.

I will provide you with an appointment card so you can verify the times and dates of appointments unless you decline the card, or if the appointment is made over the telephone or by email.

4. CONSENT TO RELEASE INFORMATION

All communications with a treating psychologist and all records relating to the provision of psychological services are confidential. Because of this, I will ask you to provide written consent before speaking to, or communicating in writing with, anyone about your care.

Examples of times you might want me to communicate with someone on your behalf might be to speak with your physician about whether the use of medication to help manage symptoms of depression is appropriate; to help arrange for you to see a psychiatrist or a neuropsychologist; or to help establish medical leave from work, or financial assistance to cover the cost of therapy, with a disability insurance provider.

SIGNING THIS FORM INDICATES THAT YOU HAVE READ AND UNDERSTAND THE CONTENT OF THIS FORM AND THAT YOU AGREE TO THE TERMS OF PAYMENT.

Name: ________________________________ Date: __________________________

Signature: ________________________________

Name: ___Dr. Patricia Turner_______________ Date: __________________________

Signature: ________________________________