



ADULT CONSENT FORM

CONSENT FOR INDIVIDUAL PSYCHOTHERAPY TREATMENT

Name: _____ Date of Birth: _____

Address: _____

I agree to take part in psychotherapy with a Registered Psychologist at Annapolis Valley Psychological Services Inc. (AVPS Inc.). I understand that the cost of therapy will be **\$220.00** an hour (including 10 minutes administrative time), which will be **paid in full at the end of each session**. I give permission for my Psychologist to discuss my progress or diagnosis with the person or organization that referred me, as well as:

_____.

CONSENT FOR INDIVIDUAL PSYCHOLOGICAL ASSESSMENT

Name: _____ Date of Birth: _____

Address: _____

I agree to undergo a Psychological Assessment with a Registered Psychologist at Annapolis Valley Psychological Services Inc. (AVPS Inc.). I understand that the cost of this assessment will be **\$220.00** an hour, which will be **paid in full at the end of each assessment session**. I give permission for my Psychologist to obtain information for my diagnosis and/or treatment plan from the person or organization that referred me, as well as:

_____.

Please continue on the other side...

I agree to the following conditions:

1. All information that I reveal to my Psychologist will be kept confidential except for those persons for whom I have given consent, unless one or more of the following situations occurs:
 - I present a danger to myself, other people or their property.
 - I report child or elder abuse. I understand that in any of these situations, my Psychologist will warn and/or protect anyone whom I might harm, and will, if necessary, call the police, hospital, or child welfare.
 - My file is subpoenaed by law with or without my consent.
 - I fail to pay my bill. I agree that in this situation my psychologist may contact a collection agency with information about my identity and the services rendered to me.
2. I will pay in full for all psychotherapy services for which I have accepted an appointment whether I keep that appointment or not, unless I give at least **24 hours notice of cancellation**. (AVPS Inc. accepts voicemail and email 24 hours a day.) Repeated missed appointments with insufficient notice could result in the termination of treatment.
3. If I am late for an appointment, I will pay in full for the appointment time, even though my session will not extend past the time for which it was booked. I agree that if I am more than 20 minutes late, the appointment may be cancelled, and I will have to pay the full fee for the appointment time.
4. This consent shall remain in effect for as long as I am being treated or assessed by my Psychologist and will be considered terminated when a period of one-year elapses since my last treatment or assessment session. If litigation or other legal issues are involved, I give permission for release of information to anyone or any organization indicated above until the legal matter in question is concluded.
5. **I understand that my confidentiality shall be protected by my Psychologist after this agreement expires unless my information is subpoenaed.**

Signature of Client

Date

Signature of Registered Psychologist

Date

*Chance Meetings explained _____