



## CONSENT FORM

### CONSENT FOR INDIVIDUAL PSYCHOLOGICAL TREATMENT (Children)

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I consent for my child 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 **\$200.00** an hour (including 10 minutes administrative time), which will be paid in full at the end of each session. I give permission for the Psychologist to discuss my child's progress or diagnosis with the person or organization that referred them, as well as:

\_\_\_\_\_.

### CONSENT FOR INDIVIDUAL PSYCHOLOGICAL ASSESSMENT (Children)

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I consent to have my child 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 **\$200.00** an hour, which will be paid in full at the end of the session. I give permission for the Psychologist to obtain information for my child's diagnosis and/or treatment plan from the person or organization that referred them, as well as:

\_\_\_\_\_.

*Please continue on the other side...*

I agree to the following conditions:

1. All information revealed to the Psychologist will be kept confidential except for those persons for whom I have given consent, unless one or more of the following situations occur:
  - They present a danger to themselves, other people or their property.
  - They report child or elder abuse. I understand that in any of these situations, the Psychologist will warn and/or protect anyone whom they might harm, and will if necessary, call the police, hospital, or child welfare.
  - My child's 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 my child.
  - **My Psychologist is required to release my name for COVID-19 tracing.**
2. I will pay in full for all psychological services for which I have accepted an appointment for my child, whether I keep that appointment or not, unless I give at least **48 hours notice of cancellation**. (Voicemail accepts messages 24 hours a day and email can be sent 24 hours a day.) Repeated missed appointments with insufficient notice could result in the termination of treatment.
3. If my child is 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 my child is 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 my child is being treated or assessed by the Psychologist and will be considered terminated when a period of one year elapses since their last treatment or assessment session. If litigation or other legal issues are involved, I give permission for the release of information to anyone or any organization indicated above until the legal matter in question is concluded.
5. **I understand that my child's confidentiality shall be protected by the Psychologist after this agreement expires unless my information is subpoenaed.**

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Signature of Parent/Guardian

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Date

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Signature of Registered Psychologist

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Date