Annapolis Valley Psychological Services Inc.

COUPLE CONSENT FORM

CONSENT FOR COUPLE PSYCHOLOGICAL TREATMENT

Names: _____ **Date of Birth:** _____

Address: _____

We agree to take part in psychotherapy with a Practicum Student at Annapolis Valley Psychological Services Inc. (AVPS Inc.). We understand that the cost of therapy will be **$60.00** an hour, which will be paid in full at the end of each session. We give permission for our Counsellor to discuss our progress or diagnosis with the person or organization that referred us, as well as our Counsellor's Supervisor, Shelley West, M.Sc.:

_____.

CONSENT FOR AUDIO AND VIDEOTAPING FOR SUPERVISION PURPOSES

We, _____ agree to have our therapy or assessment session with Practicum Student, audio and videotaped. We understand that these videos will be used solely for supervision purposes. We also understand that these videos will be reviewed by Practicum Student, and their supervisor, Shelley West, M.Sc., and that once reviewed, these videos will be deleted.

_____ Initials

Please continue on the other side…

We agree to the following conditions:

1. All information that we reveal to our Counsellor will be kept confidential except for those persons for whom we have given consent, unless one or more of the following situations occurs:

    - We present a danger to ourselves, each other, other people, or their property.
    - We report child or elder abuse. We understand that in any of these situations, our Counsellor will warn and/or protect anyone whom either of us might harm, and will, if necessary, call the police, hospital, or child welfare.
    - Our file is subpoenaed by law with or without our consent.
    - We fail to pay our bill. We agree that in this situation, our Counsellor may contact a collection agency with information about our identities and the services rendered to us.
    - **Our Counsellor is required to release our names for COVID-19 tracing.**

2. We will pay in full for all psychological services for which we have accepted an appointment whether we keep that appointment or not, unless we give at least **24 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 we are late for an appointment, we will pay in full for the appointment time, even though our session will not extend past the time for which it was booked. We agree that if we are more than 20 minutes late, the appointment may be cancelled, and we will have to pay the full fee for the appointment time.

4. This consent shall remain in effect for as long as we are being treated by our Counsellor and will be considered terminated when a period of one year elapses since our last session. If litigation or other legal issues are involved, we give permission for release of information to anyone, or any organization indicated above until the legal matter in question is concluded.

5. **We understand that our confidentiality shall be protected by our Counsellor after this agreement expires unless our information is subpoenaed.**

_____ _____

Signatures of Clients Date

_____ _____

Signature of Practicum Student Date