CONSENT FORM

Annapolis Valley Psychological Services Inc. (AVPS Inc.)
57 Webster St., Suite 208
Kentville, NS B4N 1H6

P: (902) 690-7281
F: (902) 678-7955
avps7281@gmail.com
www.avps.ca

CONSENT FOR INDIVIDUAL PSYCHOLOGICAL 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 **$190.00** 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 **$190.00** an hour, which will be paid in full at the end of the 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:

_____.

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.
    - **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 whether I keep that appointment or not, unless I 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 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