Beaches Therapy Group

Wellness, Growth & Balance | Psychotherapy Services

Practice Policies and Professional Fees.

Welcome.

Some information on the process of therapeutic change: Psychotherapy involves time spent reflecting on past events, future goals and the process of change. It takes time, patience and introspection. During the course of this work, it is the therapist's job to support and facilitate the client and his or her personal growth. Please recognize that it is a collaborative process and should you have any questions please feel free to ask.

1). Professional fees: In-Person, telephone and Skype sessions.

a. **_____ (**50 minutes for individuals, couples and families).
Services such as letters, receipt retrieval & forms are billed at $160 per hour. All sessions end ten minutes early for note taking and case planning. Fees are reviewed annually and may be subject to change. Professional fees are set in accordance with the recommended fee range for the therapist's professional regulating college.

b. Standard Legal Letters : $250.00 Minimum

c. Crisis Counselling: Beaches Therapy Group is ***not*** a crisis oriented service. If you have a crisis please call 911 or Toronto Help Line 416-408-4357 (408-HELP) or visit your nearest hospital emergency department.

Payment options:

a. Credit Card: Your Credit Card will be kept on file and stored securely. It will be used for cancellation fees. There is a $45.00 fee for declined visas. Outstanding balances will be subject to interest charges at 12% per month and may be sent to a collection agency.

b. Cheques: There is a $45.00 fee for cheques that do not clear.

c. Cash: Please bring the exact amount required. We do not carry change.

Cancellations:

Less than 48 hour notice during weekdays will incur a full charge for your missed session. Your credit card will be billed the day that your session was originally booked for.

Arriving Late: If you are late to your session it will still end at the same time it was scheduled to end and you will be billed for the complete session. If I am late your session will be extended or the fee will be adjusted accordingly.

I have read and fully understand the 48-hour cancellation policy and authorize my credit card to be billed if I provide less than 48-hour notice to cancel my appointment.

____

Client Signature **Date**

2). Scheduling: The aim is to find regular slots for you to attend on a weekly or biweekly basis, as this improves therapeutic effectiveness. Priority is given to clients with regular consistent bookings.

3). Confidentiality: All services provided to you are strictly confidential. Information about you or your situation will not be released without your informed, written consent except in the following circumstances:

a. If subpoenaed by a court of law to do;
b. If there is a risk of harm to yourself or others;
c. If a child may have been harmed in the past, at risk of harm in the present or future. In all cases, there is a legal duty to report to the Children's Aid Society.
d. If bound by law to report a colleague to my professional regulating college for professional misconduct.
e. If I am required to defend myself against a complaint field with my professional regulating college.
f. If you are impaired by drugs or alcohol and intend to drive.

Please note that for couples and families that receive service as a unit there is no confidentiality provided for between members unless otherwise expressly specified in writing.

4). Privacy Policy: We are required by provincial privacy legislation to safe guard your health information. Please note that in order for your treating therapist to provide you with psychotherapy services, he/she will collect some personal information about you. A clinical file will be kept in hard copy and both Laura Devlin and Rebecca Loucks (Clinical Directors of Beaches Therapy Group) and my treating therapist, will have access to my file.

5). Contact: Please allow up to 2 business days for your therapist to return emails and voice mails. We do not answer emails or phone messages on weekends or after 5 pm on weekdays. Email is not a secure form of communication, as a result it is important to only discuss scheduling information over email rather than personally sensitive information or materials.

6) **Consultant Relationship:**

Your Psychotherapy treatment is being provided by a Consultant Clinical Therapist who is acting as an independent Contractor, and not an employee of Beaches Therapy Group. All responsibility for the services you receive lies with your treating therapist.

New Client Intake Form

Date: ______________________________ Name of Client: ________________________

Date of Birth: ________________________ Age: _____ Gender: _____

Occupation___________________________

Marital Status/Children:____

Phone_________________ (may we leave message?) yes ☐ no ☐ Email address: ____________________

Current Address:____
Street City Prov. Postal Code

Emergency Contact: _____________________ __________________________
Name Phone Number

Referred by___________________________

DESCRIPTION OF PRESENTING PROBLEM

State in your own words the nature of your problems (i.e., What brings you in today?):

____

____

TREATMENT HISTORY

Have you been in therapy before or received any prior professional assistance for your problems?

____

____

Do you have a family physician? _____ Yes _____ No
If yes, please give his/her name(s) and telephone number(s)

____

Have you spoken to your family doctor about the nature of your difficulties?_____ Yes _____ No
Any major illness/health conditions in the past or present? _____ Yes _____ No

If yes, please describe?
____

Have you ever been hospitalized for psychological problems? _____ Yes _____ No
If yes, when and where? ____
Have you ever been diagnosed with a mental disorder such as depression, obsessive compulsive disorder, anxiety, etc. If yes, please specify:____
Have you ever attempted suicide? _____ Yes _____ No
What are your current drinking habits? ____
Do you use street drugs, illegal, or recreational drugs? ____________________________________
If so, please list: ____

THERAPY GOALS
What are you hoping to get from counselling?
____
____

INFORMED CONSENT

I have read this document, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to and understand it. My (our) signatures below indicate that I (we) accept the policies and our agreed treatment plan.

I (we) understand that I am (we are) free to stop psychotherapy for any reason at any time.

Signature: ____

____

Date: ____

CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with psychotherapy services my therapist will collect some personal information about me. I have reviewed the privacy policy and understand how it applies to me. I have been given a chance to ask any questions I have about the privacy policy and they have been answered to my satisfaction.
I understand that there are some rare exceptions to these commitments. I agree to the collection, use and disclosure of personal information about me as set our above in the privacy policy.

Signature: ____

____

Date: ____