ALLISON RICE THERAPY
& ASSOCIATES
CHANGE IS POSSIBLE

CLIENT NAME:	DATE:
CLIENT EMAIL:	CLIENT TEL:
CLIENT ADDRESS:	

Welcome

Before your first **counseling** or **clinical supervision** session, it is important that you have a general sense of what to expect from our sessions together. Please read carefully and sign below. Once completed, this will be placed in your file.

Generally speaking, what aspect of your life has brought you to see me today?

____

How did you hear about me? ____

Were you referred by a doctor or agency? _______________________________________

Are you on any psychiatric medications? If so, please list:

____

Collection and Storage of Personal Information

Storage and collection of client information is in accordance with the personal information protection act (PIPA) and in accordance with the BCACC and CCC guidelines. If you have any questions about this, please speak to me directly.

Fees

The fee is $______ for individuals and $______ for couples. Each session is 50 minutes in length and a sliding scale may be available. Longer sessions are also available, charged at $180 for an hour and a half when requested. Telephone consultations and distance counseling are charged by the ¼ hour. Payment is requested by cheque or cash at the end of each appointment, or can be made by PayPal to allison@allisonricetherapy.com if necessary.

If you are not the person making the payment, please provide contact information for the person who is going to be making the payments. Understand that I will not be discussing anything but payment arrangements with this person. **Please initial here ____.**
Contact information: ____

Appointments and Cancellation

Please feel free to call / email / text me to book an appointment at any time. If you reach my **confidential** voicemail, please leave a message and I will respond within 24 hours.
I require **24 hours notice** for cancellation of your appointment. A full session fee will be charged in the event that 24 hours notice is not provided.

The material you discuss with me will be held in strictest of confidence. Information about counseling sessions will not be released to anyone without your informed, voluntary and written consent. There are, in certain cases, exceptions in which confidentiality cannot be maintained; it is important you are aware of these before we begin:

1. Disclosure of information that a minor is in danger of harm: I am bound by law to report that the child is protected.
2. Disclosure that you have a clear and specific plan to harm yourself or another person.
3. Under British Columbia law, a clinical counsellor and / or a counsellor's notes may be subpoenaed by the courts.

The above items 1 thru 3 are the only conditions under which confidentiality cannot be maintained.

Contacting Other Health Professionals

It may be helpful or necessary for me to speak with other personal professionals who may be involved in aspects of your physical and emotional health. Wherever possible, this will be done with your understanding the intent of such contact. You have the right to know what transpired in any conversations between your counsellor and other professionals. **Please confirm by initialing here that you give your permission for me to give updates and/or discuss your case with these professionals ____.**

Other professionals involved in my health care are (e.g.: doctor(s), other therapist(s), social worker(s)):

Name:	Contact:

Consultation

In order to offer you the best possible service, I may consult with colleagues in order to receive peer supervision; your name and other identifying information would not be used.

I often present about my work, and about teaching principles of caring for others and ourselves. If you would like to permit me to use your story, I will change identifying characteristics such as your name, age, sex, and some details about your story. **Please initial here indicating your consent if applicable _____**

I see regular clinical supervision and in accordance with the BCACC best practices, I will be discussing details of your experience. **Please initial here indicating your consent _____**

Follow Up

As part of our practice, I like to follow up with you in the days after our session together. Please indicate below whether this is of interest to you, and what is the best method of communication. o No thanks o Yes, by telephone, ____ message or ____ no message. o Yes, by email. o Yes by text.	**Thank-you for taking the time to read through the above and please make sure to let me know if anything is unclear or if you have any questions. I look forward to our work together.**

☐ **I have read, understand and agree with the above.** ☐ **I am good with electronic receipts emailed to me.**

Client 1 ________________________________ **Date** ____________________________

Client 2 ________________________________ **Date** ____________________________

Allison Rice ________________________________ **Date** ____________________________