



**Counselling Costs** will be paid personally by the client or by a parent at the time of each session and submitted by the client or parent to their own Insurance Provider or Employee Assistance Program.

**Client's/Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR THOSE REQUESTING FEE REIMBURSEMENT FROM AN INSURANCE PROVIDER**

While I understand that **some** Counsellors', Social Workers', or Psychologist' fees are reimbursable by **some** insurance programs, I also understand that:

- I am responsible for paying the Therapist's fee at the time of each session and submitting my claim personally,
- Neither the Therapist nor The Counselling Corner is responsible for denied claims,
- It is my responsibility to ensure that the Therapist I am seeing meets the criteria for my particular insurance policy,
- Obtaining such reimbursement is my personal responsibility, and is not the responsibility of my Therapist or The Counselling Corner,

**Client's/Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR THOSE WHOSE PARENT(S) WILL BE PAYING FOR YOUR SESSIONS**

For the purpose of account payment, authorization is given to release length and date of session only. The therapist is not authorized to release any other information, except in accordance with law.

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**CLIENT/THERAPIST AGREEMENT FOR PROVISION OF COUNSELLING SERVICES BETWEEN:**

\_\_\_\_\_ (the “Client”) and \_\_\_\_\_ (the “Therapist”)

**The Client agrees:**

1. To provide prior notice of 24 hours if canceling an appointment. (Voicemail can be left anytime) **Failure to provide proper notice may result in a personal charge for the late cancellation.** Your prompt cancellation will permit someone else to the time and thus reduce the waiting periods for others;
2. To pay the Therapist's fees at end of each session. **If you are using an Employee Assistance Plan or Insurance Policy, you are responsible for paying the full fee and submitting your claim personally.** **It is the Client's responsibility to ensure your Therapist meets the criteria for your specific Employee Assistance Plan or Insurance Policy.** Neither the therapist nor The Counselling Corner is responsible for denied claims.
3. If you subpoena your therapist or anyone from The Counselling Corner, costs for court preparation, client rescheduling and court appearance(s) will be **paid by the client** at a rate of \$180 per hour.

**The Therapist agrees:**

1. To provide counselling assistance based upon the Client's goals.
2. To maintain the confidentiality of the Client, unless:
  - a) You may be a danger to yourself or others, or there is a reasonable suspicion of child abuse or neglect. You recognize in such circumstances that I have a legal and ethical responsibility to my professional association to notify the proper authorities.
  - b) It is appropriate to consult with a professional colleague to improve the quality of my service to you; the information shared with this professional colleague will be kept anonymous and is restricted to the information necessary to aide in meeting your desired goals and to assist me in providing adequate service. This colleague will also be held to the rules of confidentiality.
  - c) You initiate a legal action whereupon I may use information from my records to defend myself.



By signing this Letter Agreement, I confirm that I have read and understand the terms set out above and that I agree to these terms. I also agree that this contract for the Provision of Counselling Services is between the Therapist listed below and myself. I also understand that my file will be destroyed within seven (7) years of my last visit.

Client's Full Name : (Print) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Parent/Client's Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist : (Print)**

\_\_\_\_\_

**Therapist's Signature:**

\_\_\_\_\_ **Date :** \_\_\_\_\_

**Custody Arrangement papers required if parents are separated and client is 15 years old or under.** If separated or divorced both parents' signatures are required.

Custody arrangements:

Joint\_\_\_ Sole\_\_\_ None\_\_\_

**Parent/Guardian's Signature:** if Client is 15 years of age and younger

\_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian's Signature:** if Client is 15 years of age and younger

\_\_\_\_\_ Date: \_\_\_\_\_