

## INFORMATION SHEET

The purpose of this sheet is to help you make an informed choice about receiving services at Aegis. It will do this by giving information about your relationship with the people providing services here. Your signature on the reverse side of this sheet will show you understand this information and agree with it. Your agreement with this information does not prevent you from disagreeing with it later. You may also choose to stop receiving services at any time without penalty on 24 hours notice.

**INITIAL ASSESSMENT.** Treatment begins with an initial assessment that is designed to help the service provider and client get to know each other better, and to provide information that will guide treatment planning. The assessment is made up of a clinical interview and may include paper and pencil self report forms and/or the service provider talking with professionals and family members (with the client's consent) who know the client well.

**TREATMENT PLANNING.** Once the assessment has been completed, the service provider will provide treatment recommendations, outline treatment options, and negotiate a plan of action for therapy that is based on the full informed consent of the client. The client's consent to treatment will be based on full knowledge of the anticipated risks and benefits.

**RISKS AND BENEFITS.** Possible benefits to the client include gaining a better understanding of themselves, learning how to cope with and/or solve their problems, and improving their relationships with other people. Possible risks are that the therapy may not work, distressing emotions may be stimulated, and relationships may be disrupted. In short, while personal life change can be very beneficial, it can also be very stressful.

**CONFIDENTIALITY.** The client's right to privacy will be respected to the fullest extent permissible under law, while attempting to act in the client's best interest. Information about the client will not ordinarily pass outside the practice, except under the following circumstances.

- If the client seems likely to do serious harm to myself or to others, other people may be asked to help prevent this from happening.
- If the client gives information about a child in need protection, or a vulnerable adult being abused/neglected, the appropriate authorities may have to be notified.
- If a court of law orders disclosure of clinical records, then the client's file may have to be produced.

Information will also be released to third parties (e.g., insurance companies) who are paying the cost of the services, but only to the extent necessary for reimbursement. Otherwise, information is only released if the client or the client's legal representative gives informed (usually written) consent. All clinical records are destroyed seven years after the client is last seen, or in the case of minors, seven years after their 19<sup>th</sup> birthday.

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**MISSED APPOINTMENTS.** Clients who give 24 prior hours notice when they are unable to attend sessions, have the fee for that session forgiven. If it is not possible to give 24 hours notice, as in the case of sudden illness or accidental injury, the fee is also forgiven. Otherwise, the client, client's parent/guardian or other third party will be billed the **full session fee**.

**PHYSICIAN'S INVOLVEMENT.** The client consents to releasing information in writing or in spoken communication to their physician(s), and any other professionals by listing their names below. This information will usually be discussed with the client before it is released. In the case of written information, the client will normally offered an opportunity to review it before it is released, and will receive a copy.

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**FEE PAYMENT.** The basic rate is \$175.00 for a 50-minute session. Payment will be due at the time services are rendered. Fees for longer or shorter sessions will be prorated from these basic or reduced amounts. The client or the client's parent(s)/guardian(s) will be responsible for paying this fee, and for obtaining any reimbursement available from third parties. Defaulted accounts may be sent to collection and/ or small claims court.

**METHOD OF PAYMENT.** Please indicate who will be paying the cost of sessions by checking one of the options below, and by providing billing information.

- Self
  
- Friend/family \_\_\_\_\_
  
- Other \_\_\_\_\_

**INTERRUPTION OF SERVICE.** If the service provider for any reason becomes unavailable to provide treatment services or the client is not benefiting from treatment and/or decides to withdraw, the names of alternate service providers will be provided whenever possible. In the event of the service provider's death or disability, this responsibility and responsibility for the client's clinical records will be assigned to Dr. Galia Artzy, 202 - 1711 Cook Street, Victoria, British Columbia.

Client:	_____	_____	_____
	(signature)	(printed name)	(date)
Parent/Guardian or Legal Representative:	_____	_____	_____
	(signature)	(printed name)	(date)
Service Provider:	_____	_____	_____
	(signature)	(printed name)	(date)