Dr. Joti Samra, R.Psych. | Clinical Psychologist

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CONSENT TO TREATMENT

(REVISED AUGUST 19, 2011)

Name of Client: ______________________

Date of Birth: ______________________

File Number: ______________________

Referral Source: ______________________

Address: ______________________

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Phone Number: ______________________

This form provides information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with Dr. Joti Samra. Your signature at the bottom indicates that you understand the information and freely consent to participate in the services described below.

PURPOSE OF TREATMENT

You have been referred by ________________________________, for psychological treatment. Psychological treatment (therapy) can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems (e.g., anxiety, anger, depression, parenting or relationship concerns). Therapy can help a person to develop new skills and to change behaviour patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others. Prior to beginning therapy, a brief assessment will be conducted for the purpose of treatment planning. The assessment will focus on understanding your goals for therapy. Assessment may also involve assessing your present level of cognitive and emotional functioning, including learning disabilities, academic functioning, and personality functioning and/or coping styles. The assessment process generally involves an informational interview and may involve the administration of one or more educational and/or psychological tests. You may also be asked for your consent for Dr. Samra to obtain information from collateral sources. Throughout the assessment and treatment process, you have the right to inquire about the nature or purpose of all procedures. You also have the right to know any test results, interpretation, and recommendations.

BENEFITS AND RISKS

Therapy can assist people in gaining new understandings about their problems and to learn new ways of coping with and solving these problems (e.g., anxiety, anger, depression, relationship concerns). While there are potential benefits to therapy, there is no guarantee of success. Furthermore, during therapy you may be asked about personal experiences and events which may evoke strong feelings. Changes in awareness may alter self-perceptions and ways of relating to others. The process of personal change can

be quite varied and individual. It is important that you mention promptly any concerns or questions to Dr. Samra that you may have at any time during the assessment and treatment process.

CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

All communications with Dr. Samra, and all records relating to the provision of psychological services to you will not be released to any other person or organization without your permission. It is usually helpful for Dr. Samra to be able to receive your consent to speak with your primary health care provider (e.g., family physician) and/or other professionals that are involved in your care (e.g., psychiatrist). The law places certain limits on the confidential nature of the psychological services provided to clients. Typically these limits on confidentiality may arise if Dr. Samra perceives that there is risk of harm in situations such as the following: If you present an imminent danger to yourself or others the law requires that steps be taken to prevent such harm; if a child is in need of protection a report must be filed with the appropriate agency or authority; if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency; or if a court orders the disclosure of records. In the rare event of any of these situations, Dr. Samra would, if appropriate, discuss her intentions with you before an action is taken, and disclosure of information would be limited to the minimum necessary to ensure safety.

Please indicate if you would like Dr. Samra to communicate with any of your other treatment providers:

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________

ACKNOWLEDGMENT AND CONSENT

I acknowledge that I have had the opportunity to carefully read this document and to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document, that it records my consent and I been provided with a copy of it. In knowledge and appreciation of the benefits and risks as made known to me by Dr. Samra, and as reflected in this form, I hereby give my consent to participate in therapy.
I further acknowledge that Dr. Samra must obtain my informed consent before changing or altering the nature of the assessment or psychological services provided to me.

Client Name: ______________________________	**Witness Name:** ______________________________
Client Signature: ______________________________	**Witness Signature:** ______________________________
Date: ______________________________	**Date:** ______________________________