Psychotherapist
Jennifer Elder

# CONSENT FORM

***NOTE TO CLIENT:*** *I would like your informed consent for the services I provide. This means that I would like you to understand the services I hope to provide to you, the cost involved, and what I do with the personal information I obtain about you. If you have any questions on any of the information below, please ask for clarification.*

**CONSENT FOR TREATMENT**: I understand that all information shared with **Jennifer Elder** is confidential and, except as is set out below, no information will be released without my consent. My consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is a risk of imminent danger to myself or to another person. In this case, the clinician is ethically and legally bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse. The clinician is legally required to take steps to protect the child/elder and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician is bound by law to comply with such requests.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

**CONSENT FOR THE COST OF SERVICES:** Fees are paid at the time of service, and a receipt will be provided. A fee will be charged for missed sessions or sessions cancelled with less than 24 hours.

Psychotherapy services may be covered or partially covered by extended health care insurance plans.

OHIP does not cover psychotherapy services, however fees that are not reimbursed through an extended health plan are tax deductible as a medical expense.

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**CONSENT FOR PERSONAL INFORMATION:** I understand that to provide me with psychotherapeutic services, **Jennifer Elder** will collect some personal information about me (e.g. birthdate, address and other contact information).

I have reviewed and agree to the terms of Jennifer Elder's *Privacy Policy,* including the purposes for which my personal information will be collected, used and disclosed. I understand the steps taken to protect my personal information, how this *Privacy Policy* applies to me, and my right to review it or have any questions answered.

My practice is supervised by **Dr. Sharon Francis Harrison, Ph.D., C. Psych.** (#2397) She is a registered psychologist in Ottawa. She may access your file in order to supervise the counselling services provided.

I understand that, as explained above, there are some rare, legally prescribed exceptions to these commitments.

I hereby consent to the provision of psychotherapeutic services as provided above.

Signature: _____

Date: _____

Print Name: _____

Jennifer Elder
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