DR. JODY CARRINGTON

Psychologist. Mother. Believer.

C. Psych #3234 AB
OLDS, ALBERTA
403.875.6554

~INFORMED CONSENT FOR ASSESSMENT AND TREATMENT~

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____ Email: _____

The type and extent of services that you will receive will be determined following an initial assessment and thorough discussion with you. The goal of the assessment process is to determine the best course of treatment for you and whether you feel that I will be a good "fit" for you. It is important to me to get a clear understanding of your "story" in order to best understand if I can be helpful to you, so our initial meeting usually takes one-two hours. Typically, treatment, if required, is provided over the course of several weeks and will involve a course that we are both comfortable with.

I understand that all information shared with Dr. Carrington is confidential and no information will be released without my consent.

I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself, my child or to another person, Dr. Carrington is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being neglected or abused or is at risk of such abuse, Dr. Carrington is legally required to take steps to protect the child or elder, and to inform the proper authorities.

C. When a valid court order is issued for counselling records, Dr. Carrington is bound by law to comply with such requests.

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Some important things to remember:

You may request to review your file, including case notes and reports at any time.

If you have any questions regarding this consent form or about the services offered, you may discuss them with Dr. Carrington.

I understand that I may stop the assessment or treatment process at any time.

Dr. Carrington's rates, in line with provincial standards, are $190/hour, unless otherwise determined. An invoice will be provided at the end of every calendar month and payment is due on receipt of this invoice. You will be able to use this invoice for any insurance claims that you deem appropriate to your specific benefit plan, if one is available to you.

I have read the above material, and I fully understand my rights and obligations as a client of Dr. Carrington. I freely agree to participate in assessment and/or treatment services with Dr. Carrington, with the understanding that I can withdraw my consent at any time. I also understand the limits of confidentiality as indicated above and which were explained to me by Dr. Carrington.

_____ _____

Client Signature Date

_____ _____

Dr. Carrington's Signature Date