BRENDA B. ISEN M.S.W., R.S.W.

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Registration # 324141
Ontario College of Social Workers
And Social Service Workers

CONSULTATION AND PSYCHOTHERAPY CONSENT FORM

I have read and/or have had explained or presented to me the following information relating to my consultation and treatment. By signing below, I am indicating that I consent to this consultation and/or treatment.

Confidentiality

I understand that the matters discussed in therapy are personal and will be kept within the strictest confidence. I understand that information obtained will only be shared with others with my written consent. I have also been advised that all regulated health providers are subject to the rule that this assurance of confidentiality is waved in the following rare situations:
-When there is suspicion of child abuse – When clients pose a significant danger to themselves or others -When clients report sexual abuse by a health care professional -if there is a true inability to care for oneself -or if the court issues a subpoena for records. In all these situations, the written records will not be released without the opportunity for myself to review them.

I understand that communication/information sent and/or received by email; text; or facetime/skype cannot be guaranteed to be confidential.

Cancelation and Rescheduling

I understand that the appointment times I am given have been reserved for me, and I will make every effort to attend punctually. I realize that, in order not to be charged the full fee for a cancelled or rescheduled appointment I am required to call 24 hours in advance of my appointment time and date, and that, if my appointment is scheduled for a Monday, Saturday or Sunday, it must be cancelled by end of working day on the preceding Friday. I understand that cancellation of an appointment must be done by telephone and that I may leave a voice mail message if I am unable to speak directly with my therapist.

_____ _____

Name of Client Signature of Client

_____ _____

Date Signature of Witness