



**FERNIE COUNSELLING AND CONSULTING  
Agreement for Services**

Client: \_\_\_\_\_

Client: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (cell) \_\_\_\_\_

Child: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_ M \_\_ F \_\_

**PAYMENT FOR SERVICES RENDERED**

Please read the following carefully and ask any you may have before signing this.  
Payment is due at the time of services. I accept cash and checks only.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. The fee is \$130.00 per 50-minute session.

Cancellation policy: All clients will provide *Fernie Counselling & Consulting* with at least 24 hours notice of an appointment cancellation. If you cancel within 24 hours of your appointment, or if you fail to show, you will be responsible for the fee of the scheduled session.

*Fernie Counselling and Consulting* will not get involved in Custody Court because it is counterproductive to therapy.

If circumstances of unusual financial hardship exist, a negotiated payment plan of installments may be available.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, *Fernie Counselling and Consulting* has the option of using legal means to secure the payment.

If such legal action is necessary, its costs will be included in the claim.

**FINANCIAL RESPONSIBILITY**

I accept the financial responsibility for the charges incurred. I understand that payment is due at time of services. Any other arrangement must be approved by Cheryl Hulburd MSW RSW RPT in advance.

**\*NO-SHOW AND CANCELLATIONS POLICY: Your visit has been reserved for you, therefore 24-hour notice is required for cancellations or you will be charged your full session fee amount.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIALITY**

Although most information discussed in session is confidential, there are exceptions.

There is an obligation by law and professional ethics to report to appropriate agencies concerning issues of:

Child physical and sexual abuse-child protection concerns, criminal intent, potential danger to oneself or others (medical emergencies or threats of violence).

Information may also be subpoenaed by a court of law.

**Please feel free to discuss any limitations or concerns regarding this issue of confidentiality.**

**Authorization for Release Of Information To Others**

I hereby authorize Cheryl Hulburd, an MSW student, to consult or share information as needed for the purpose of providing services to the above named client. I have indicated with initials those programs/individuals with whom information may be shared.

Client's Initials

\_\_\_\_\_ Family Physician \_\_\_\_\_ (name)

\_\_\_\_\_ Psychologist/psychiatrist \_\_\_\_\_ (name)

\_\_\_\_\_ MCFD Social Worker \_\_\_\_\_ (name)

\_\_\_\_\_ Teacher \_\_\_\_\_ (name)

\_\_\_\_\_ Social work/counselor Supervision \_\_\_\_\_ (name)

\_\_\_\_\_ Other (please specify) \_\_\_\_\_ (name)

Other specific requests regarding information sharing: \_\_\_\_\_

I hereby give my consent for sharing information for the purpose of supervision/consultation. I am also aware that information must be reported to the appropriate agencies any issues concerning child abuse, intent to harm, or intent to commit suicide. I am also aware that Cheryl Hulburd may be subpoenaed by a court of law to provide information.

This consent will expire upon termination of services after one year, or upon my request which ever comes first.

**Release For Videotaping and Recording**

I understand and give my permission to Cheryl Hulburd, MSW, RSW, RPT for videotaping and /or recording the therapeutic sessions of my child(ren). This information will be used solely for supervision consultation.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Alert and Medical Information**

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Client's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Allergies:

Chronic Medical Conditions:

Regular Medications:

Physical Limitations:

Behavioral Concerns ( eg; Suicide, physical aggression, substance abuse):

Other:

**Signed:** \_\_\_\_\_ **(Parent/ Guardian)**      **Date:** \_\_\_\_\_

\_\_\_\_\_ **(Clinical Social Worker)** **Date:** \_\_\_\_\_

**Plan for Service:**

On a scale of 1-10, please circle your current functioning. 1 2 3 4 5 6 7 8 9 10

What is the presenting problem?

Goals (specific changes to be made)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISCLOSURE STATEMENT**

I am a Registered Social Worker in the Province of British Columbia and a Candidate for a Registered Play Therapist in Canada. I am a private practitioner at Fernie Counselling and Consulting and work with children, youth, adults, couples, and families. Additionally I am a certified Family Law Mediator.

Over the years I have developed several specialties. One of those is working with trauma victims, especially with survivors of any kind of childhood abuse. Some of the techniques I use are Guided Imagery, Free Writing, Therapeutic Drawing, Art Therapy, Sand Tray Therapy, Workbook pages and Therapeutic Readings. Another specialty of mine is Undirected Play Therapy. However, like most clinicians, I have also developed an eclectic style that is adaptable for the many concerns that come with my diverse Clientele.

A "good fit" in the therapeutic relationship is important to me. Therefore, if you feel that counselling is not working out for you, or that you would prefer to terminate the therapy and try another counselor, PLEASE LET ME KNOW!

Feel free to discuss any questions about your therapy with me that may arise during your treatment.

Thank you,  
Cheryl Hulburd MSW RSW RPT

**CLIENT AGREEMENT**

I, \_\_\_\_\_ give consent to be evaluated and treated by Cheryl Hulburd MSW RSW RPT. I understand that I may withdraw my consent for treatment in writing at any time.

I understand the above policy.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Date \_\_\_\_\_