



AGREEMENT FOR SERVICES

Client: _____

Client: _____

Address: _____

Email: _____

Phone (Home): _____ Work: _____

Cell: _____

I, _____ give my consent to be evaluated and treated by Cheryl Hurlburt MSW, RSW, RPS, CPS, EMDR Certified. I understand that I may withdraw my consent for treatment in writing at any time.

PAYMENT FOR SERVICES RENDERED

Please read the following carefully and ask any questions you may have before signing this. A credit card is required on file prior to scheduling sessions. You will be expected to pay for each session at the time it is held, unless we agree otherwise. The fee is \$200.00 per 50-minute session (therapeutic hour) for children. The fee for adults is \$225.00 per 75 minute session.

EMDR treatment fee is 200.00 per 50-minute session (therapeutic hour).

LENS treatment is 190.00 (time may vary).

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. 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.

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

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.

I have read and understand 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: _____

(name) _____

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 whichever comes first.

RELEASE FOR VIDEOTAPING AND RECORDING CHILDREN

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

Signed: _____ Date: _____

Emergency Contact: _____

Client's Physician: _____

Allergies: _____

Alert and Medical Information: _____

Phone: _____

Phone: _____

Chronic Medical Conditions: _____

Regular Medications: _____

Physical Limitations: _____

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

Other: _____

Signed: (Parent/ Guardian) _____

Date: _____

Signed: (Clinical Social Worker) _____

Date: _____

Plan for Service: _____

On a scale of 1-10, please select your current functioning. Note: 1 equals lowest functioning, 10 equals highest 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 private practitioner at Fernie Counselling and Consulting and work with children, youth, adults, couples, and families. I am a Registered Social Worker in the Province of British Columbia, a Registered Play Therapist Supervisor with the Association for Play Therapy in the United States, a Certified Play Therapist and Supervisor with the Canadian Association for Play Therapy, Certified EMDR Trauma Therapist with EMDRIA Canada, EMDRIA Approved Consultant, and Certified Neurotherapist/LENS provider. Additionally, I am licensed as a Family Law Mediator by the Continuing Legal Education Society of British Columbia.

Over the years, I have developed several specialties. Trauma, childhood difficulties utilizing Play Therapy, Eating Disorders, concussions, anxiety, ADD/ADHD and pain treatment. I use numerous techniques such as Expressive Therapy, Guided Imagery, Free Writing, Art Therapy, Play Therapy, Sand Tray Therapy, Therapeutic Readings, EMDR, and Neurofeedback. Like most clinicians, I have 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 counseling is not working out for you, or that you would prefer to terminate the therapy and try another counsellor, PLEASE LET ME KNOW!
Feel free to discuss any questions about your therapy with me that may arise during your treatment.

Sincerely,

Cheryl Hulburd

MSW, RSW, RPS, CPS, EMDR Certified, EMDRIA Approved Consultant, Certified Neurotherapist