FERNIE COUNSELLING AND CONSULTING

Agreement for Services

Client: _____

Client:_____
Address:

_____

_____

Email:_____

Phone: (Home) _____(Work)_____ (cell) _____

Child: _____ D.O.B._____ Age: ____ M __ F__

CLIENT AGREEMENT FORM

I, _____give my consent to be evaluated and treated by Cheryl Hulburd MSW, RSW, RPT, CPT, EMDR Certified. I understand that I may withdraw my consent for treatment in writing at any time.

I, _____give my consent for my child(ren)_____s_

to be evaluated and treated by Cheryl Huburd MSW, RSW, RPT, CPT, EMDR Certified. I understand that I may withdaw my consent for treatment in writing at any time.

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 $150.00 per 50-minute session for children and $225.00 per 75 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.

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 in formation 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/consultaion. 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 Children

I understand and give my permission to Cheryl Hulburd, MSW, RSW, 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_____

Care Card Number_____

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 private practitioner at Fernie Counselling and Consulting and work with children, youth, adults, couples, and families. I am a Reistered Social Worker in the Province of British Columbia, a Registered Play Therapist with the Assoicaiontion for Play therapy in the United States, a Certified Play Therapist with the Canadian Association for Play Therapy and EMDR Certified

with EMDRIA and EMDR CA. 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 and Eating Disorders. I use numerous techniques such as Expressive Therapy Guided Imagery, Free Writing, Therapuetic Drawing, Art Therapy , Play Therapy, Sand Tray Therapy, Workbook Pages, Therapeutic Readings, Undirectred Child Centered Play Theapy, and EMDR. 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 realtionship is importatn to me.
Therefore, if you feel that counseliing 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 an questions about your therapy with me that may arise during your treatment.

Sincerrely,
Cheryl Hulburd MSW, RSW, RPT, CPT, EMDR Certified