MENTAL HEALTH SERVICES AGREEMENT

Confidentiality

In providing you with services such as assessment and therapy, it is very important that you can speak openly with your Therapist in order to benefit from the service. To encourage this openness, your Therapist agrees to keep the information that you share with them confidential. This means that information shared in the course of an assessment or therapy will not be shared with anyone without your consent. To protect the safety of vulnerable persons or your own safety, and in certain other unusual circumstances, however, further exception will be made to this confidentiality agreement. The following situations may require your Therapist to share pertinent information with another party:

1. If you present a risk of safety to yourself or others, this may be reported to others who can ensure or maintain your safety or the safety of others.
2. If you disclose knowledge that yourself or another person under the age of 19, an elderly person, or any other vulnerable person may be at risk of harm (e.g., physical, verbal, sexual abuse or neglect), this will be reported to the appropriate Child or Adult Welfare agency.
3. If you sign a release of information for a third party such as a physician, social worker, lawyer, insurance company, teacher, etc., the information will be released as requested. The specifics will be discussed before information is released.

   Please note: for clients being seen as a couple or family, release of information requires written consent of all family members involved in therapy. Information cannot be released with only one person's signature.
4. If you make an ethical or legal complaint against your Therapist, they are not bound to keep information related to the complaint confidential. This is to allow them to explain their behavior in the appropriate legal forum.
5. If a court judge subpoenas your file, or as otherwise required by law.

Information for Parents

If your child is receiving mental health services, please understand that all attempts to include you in the treatment will be made. In most cases, however, your older child/adolescent retains the legal right to consent to treatment.

If services are for a minor, by signing below you are agreeing that you have the legal right to consent for this child. If divorced or separated, you are following any existing legal agreement with respect to notifying or seeking consent from the child's other parent. If disagreement arises between parents consenting to psychological care, it is the position of Lesley Hartman & Associates, Inc. to continue providing services to the child as long as the treating Therapist has both the informed consent of the child and one custodial parent.

Your child's confidentiality will be protected by their Therapist, except in situations as mentioned above, i.e. where they may be at risk of harm to themselves or others, when they are being harmed by someone else, or when they give their consent for their Therapist to speak with you or someone else. The benefit of this for your child/adolescent is that they may feel more comfortable sharing information with the Therapist, and therefore will benefit more from the services.

Other information about our psychological services

1. Your Therapist is professionally required to keep records of their contact with you. These health records will be kept in a secure locked filing cabinet.
2. Your name, address, phone number, email address, and family physician's name will be stored in the LHA Inc. practice management software. This software complies with provincial and federal privacy standards for health information. Technical support and administrative staff may be able to view your information if the need arises. These staff members have signed confidentiality agreements and will not access this information unless necessary for administrative or IT support functions.
3. Neither the Therapist nor the client will take audio or video recording of sessions without written consent from both parties.
4. There is a fee for private mental health services, as these are not covered by government health plans. The fee for service is $105.00 per 50-minute session.
5. At least 24 business hours' cancellation notice is required to avoid charges for missed appointments. Monday appointments must be cancelled by 12:00 pm noon on Friday, and appointments scheduled on the first day following a holiday must be cancelled by 12:00 pm noon on the last business day before the holiday. Appointments that are not cancelled within policy guidelines will incur a charge equivalent to the scheduled session's full fee. Exceptions can be made for extenuating circumstances, at your therapist's discretion. Outstanding balances must be paid in full prior to rescheduling.
6. Your Therapist cannot direct bill insurance companies. Therefore, you will be expected to pay for the session upon receipt of the service and may send in the receipts to receive your reimbursement from your insurance company.
7. Your Therapist books appointments on specified days. Evening hours may be limited. This means you may not always get your first choice of appointment times.
8. Your Therapist may not be able to accommodate mental health emergencies. In these cases, they will provide you with information about where to access immediate assistance.
9. Although we take precaution to minimize risk of privacy breach through our office email, we cannot eliminate that risk. Please be aware that email communication can be intercepted in transmission or misdirected. Consider communicating any sensitive information by telephone, fax, or email.

I have read the above information and/or it has been reviewed with me. I understand the limits of confidentiality and the terms of receiving these mental health services. I accept them and consent to mental health services.

Client Signature: _____

Client Name: _____

Signature of Legal Guardian (if applicable): _____

Date: _____