Successful Families Inc.

Assessments, Consultation, Counselling, Mediation

INTAKE FORM

BASIC INFORMATION:

Your Name _____ Date _____/_____/_____

Home Address (including postal code):

_____

_____

_____

Email Address: _____

Home # (_____)_____ Work # (_____)_____

Cell # (_____)_____ Fax # (_____)_____

Birth Date _____/_____/_____ Birth Place _____

Present Relationship Status:

___ Married ___ Common Law ___ Separated ___ Divorced ___ Widowed ___Single

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FAMILY COMPOSITION:

(List yourself and other members involved)

Name_____ Age_____ Birth Date_____

Birth Place_____

Occupation or Current School_____

Name_____ Age_____ Birth Date_____

Birth Place_____

Occupation or Current School_____

Name_____ Age_____ Birth Date_____

Birth Place_____

Occupation or Current School_____

Name_____ Age_____ Birth Date_____

Birth Place_____

Occupation or Current School_____

_____

_____

NAME ALL PERSONS WITH WHOM YOU RESIDE (INCLUDING CHILDREN, PARTNERS, ROOMERS, RELATIVES, CAREGIVERS, ETC.)

_____

_____

RECENT MAJOR LIFE EVENTS -- POSITIVE AND NEGATIVE? (EG., LOSSESS, ACCIDENTS, CHANGE OF EMPLOYMENT, BIRTH OF CHILD, MARRIAGE, ETC.(PLEASE LIST AND THESE WILL BE DISCUSSED ON AN INDIVUDAL BASIS.)

_____

_____

_____

_____

HAVE THERE BEEN ANY INCIDENTS OF VERBAL AND/OR

EMOTIONAL ABUSE ? **YES NO**

IN THE PAST SIX MONTHS? **YES NO**

OR AT ANY TIME IN THE RELATIONSHIP? **YES NO**

HAVE THERE BEEN ANY INCIDENTS OF VIOLENCE? **YES NO**

IN THE PAST SIX MONTHS? **YES NO**

OR AT ANY TIME IN THE RELATIONSHIP? **YES NO**

GIVE SPECIFICS ON THE ABOVE:

_____ _

_____

_____

THE REASON YOU ARE SEEKING SERVICES:

_____

_____

_____

DISCUSS ANY ADDITIONAL CONCERNS:

_____

_____

_____

PREVIOUS AND CURRENT COLLATERAL SOURCES (E.G., SOCIAL WORKERS, PSYCHOLOGISTS, PSYCHIATRISTS, SCHOOL, BOARDS OF EDUCATION, FAMILY DOCTORS, PEDIATRICIANS, HOSPITALS, CAS, CCAS, JF&CS, OTHER RELEVANT AGENCIES OR SOURCES):

SOURCE/CONTACT FULL ADDRESS (POSTAL CODE) PHONE DATES

_____

_____

_____

_____

_____

IN CASE OF AN EMERGENCY WHO SHOULD BE NOTIFIED?

_____

_____

CLIENT AGREEMENT AND NOTIFICATION

This document contains important information about Ms. Hayes professional services and business practices. Please read it carefully. It explains many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing.

CONFIDENTIALITY

In the case of counselling and other applicable services, the confidentiality of all communications between a client and Ms. Hayes is protected by law and she can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release clients' protected health information without their authorization. To improve your treatment, Ms. Hayes can release this information so she can consult with other professionals. Unless you instruct her otherwise, Ms. Hayes will not tell you when she has these consultations. If applicable, she may release information to your insurance company to obtain authorization for treatment, payment or for other purposes, such as for quality improvement programs. In these cases, Ms. Hayes will release only the minimum information necessary to accomplish the specific purpose for which the information was requested. In some situations, she can also be compelled to release client records by the courts as part of a legal service.

In the following situations, Ms. Hayes must take action to protect people from harm, even though that requires revealing some information about a client's treatment. If she believes that a child, an elderly person, or a disabled person is being abused, she must file a report with the appropriate agency. If she believes that a client is threatening serious bodily harm to themselves or to another, she is required to take protective actions which may include contacting authorities, family members or others who can help provide protection. Ms. Hayes will inform you of these reports. The standards of her profession require that she record and maintain appropriate treatment records. You have the right to request that your information be amended or restricted from certain uses and disclosures. While Ms. Hayes will seek to honor your requests, she may decide that it is not prudent for her to agree to your requests.

Additionally, your services may not be a confidential process. Please enquire about confidentiality practices specifically if you are engaged in a custody and access assessment, parenting coordination, mediation or arbitration.

CONTACTING YOUR THERAPIST

Due to our work schedule, your therapist is not immediately available by telephone. While we are usually in the office Monday to Thursday between 10am and 5pm, your therapist will not likely answer the phone. Our telephone is answered by our assistants or by voice mail. We make every effort to return your call as soon as possible. If you are difficult to reach, please inform us of some times when you will be available. The best way to communicate will likely be through a direct email to your therapist or alternatively, at info@successfulfamilies.ca. Please be mindful that we are NOT an emergency service, and if you require assistance in that manner, contact your family physician or go to the nearest emergency room. If you feel that you need immediate assistance as there is a life-threatening emergency, please call 911 or your local police. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

FEE POLICIES AND PROCEDURES

1. Your fee will be negotiated between Successful Families Inc. and you. Periodically, professionals increase their fees and will discuss any change with you.
2. You may be asked for a deposit/retainer and billed monthly for services during the month. If not, payment is expected at the time of your session.
3. You may pay by e-transfer or credit card. Please send your e-transfer to michelle@successfulfamilies.ca
4. We may ask you for authorization for credit card payment of any fees not paid at the end of a calendar month or within one month of receipt of the statement. In the event there is any problem with collecting fees, we will charge interest of 1% per month on the outstanding balance. In the event we must incur costs to collect fees, those costs will be the responsibility of the client.
5. If you find an error in your statement, informing us in writing will help us deal most quickly with your concern.
6. Cancellation Policy: If you need to cancel or reschedule an appointment, please call as soon as possible and not less than 48 business-day hours in advance to avoid a charge (i.e. canceling

a Monday appointment on Friday is not sufficient notice). If you do not cancel at least 48 business-day hours in advance, you will be responsible for the fee for the session. We have this policy because a time commitment is made to you and is held exclusively for you.

7. If your therapist is deposed or called to testify in court on any issue regarding this case, payment will be made seven (7) office days in advance to schedule her testimony time (a minimum of a half-day with no on-call), and she will be paid her hourly fee for the testimony time plus preparation and travel time needed for her testimony.

8. By engaging in services you are agreeing to pay the fee for each 50-minute session at the time of service. If it is necessary for your therapist to make phone calls, review documents or write documents as part of their services to you, those services will be charged to you at the same rate as for direct treatment.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement.

_____

Client Name

_____ _____

Client Signature Date

_____ _____

Therapist: Date