ONLINE VERSION 1.2

P.O. Box 27002
Victoria, BC
V9B 5S4

Print Form | Reset Form | Submit by Email

impressions inc. Family Counselling Services

DOCUMENT VERSION
2020
FOR ADMIN USE ONLY

Upon completing this Agreement, save it on your computer and then submit it using the "E-MAIL" link provided.

OFFICE USE ONLY

AFFIX PATIENT ID CODE HERE

Tel: (778)557-8478
Toll: (866)708-3501
Fax: (778)557-8558

GROUP INTAKE ASSESSMENT

ON-LINE GROUP PROGRAM - GENERAL INTAKE FORM

APPLICATION PACKAGE — *PROTECTED B DOCUMENT*

ON-LINE GROUP INTAKE

PATIENT NAME: _____

BIRTHDATE: _____ AGE: _____

GENDER: _____

PROGRAM APPLIED: _____

PHONE: _____

E-MAIL: _____

DATE RECEIVED: _____

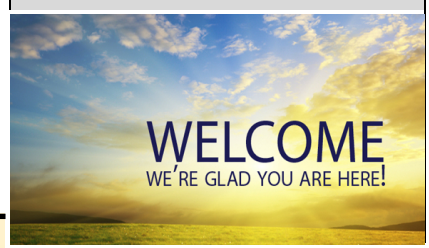
DATE REVIEWED: _____

DISPOSITION: _____ DATE: _____

This form and its contents are Protected, when completed, under the Health Services Act of Canada

Please complete this General Intake Assessment and submit to your therapist, upon completion. This form is a mandatory requirement for services and must be completed by the individual, or their authorized representative. This form constitutes the "informed consent" of the individual identified and is utilized for the purposes of effective case management practices. No personal information or data collected is ever shared, unless required by Law under Court Order.

WELCOME TO IMPRESSIONS FAMILY COUNSELLING SERVICES INC.



GROUP THERAPY CONSENT, POLICIES AND AGREEMENT

All persons participating in group counselling must read and sign this agreement. If you do not understand any part of this intake/agreement form, please ask any questions prior to signing the agreement.

You may also receive a copy of this agreement, therapist. All persons must also sign the HIPAA form as well.

By virtue of completing and submitting this agreement, you are hereby granting your permission for IMPRESSIONS FCS Inc. to provide group counselling services in the form of weekly self-expression, support and skill-building groups.

Participating in group counselling can result in numerous benefits,including improving interpersonal relationships and resolving the concerns that led you to seek group counselling. Working toward these benefits, however, requires active involvement, honesty and openness on your part.

It is possible that group counselling may not work for you. Even so, many people find that group counselling is worth the difficulty it may entail, leading them to a satisfying experience overall and insights achieved.

GROUP STRUCTURE, FREQUENCY and GUIDELINES

GROUP NAME:	
GROUP DAY AND TIME:	
PROGRAM LENGTH:	8 WEEKS
MAX. PARTICIPANTS:	
ATTENDANCE:	Group is a weekly commitment and your attendance is expected, unless prior obligation has been discussed with your therapist.
Payment/Fees:	$72 per weekly session / $499 package There is no prorated fee offered for missed groups and all payments received are nonrefundable.

IMPORTANT NOTICE:

I understand that anything said in therapy is confidential, except for the following limitations: : child abuse and/or neglect (which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out, physical abuse, etc); vulnerable adult abuse or neglect; threats to harm oneself; threats regarding harm to another person; a court subpoena, my specific request, in writing to disclose information to a third party.

FACESHEET-GROUP APPLICATION PACKAGE

impressions inc.
Family Counselling Services

Group Counselling

We're HERE for YOU!

Vancouver Island

www.impressions-counselling.org

Welcome!

Providing therapeutic counselling services and coaching programs to children/youth, adults, seniors, veterans and EMS personnel.

Our Small Group
On-line Counselling Services

Office: (778) 557-8478

TOLL FREE (866) 708-3501

E-Mail: admin@impressions-counselling.org

Psychology Today Therapists

impressions inc.
Family Counselling Services

P.O. Box 27002
Victoria, BC V9B 5S4

Mental health BEGINS WITH Me

Counselling

Vancouver Island SERVICES

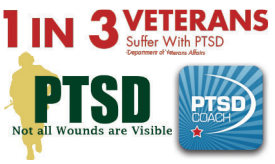
Our services are designed to complement the specific needs of our collateral social service agencies. Our comprehensive services include client-based therapeutic interventions, consistent collaborative processes and thorough reporting structures. Our years of experience and active stakeholder engagements support your clients in meeting their expectations and realizing successful outcomes in daily living.

See our Ad in The SOS Children's Safety Magazine Spring 2017 Edition

Our On-line Group Services

We provide 8 week on-line group programs for men, adolescents and children 10 years of age or older in small participant groups aimed at increasing skills development and overall health and well-being. Common issues often identified include:

- anger management
- domestic violence
- effective communication skills
- confidence & self-esteem
- abuse & neglect
- bullying
- discrimination
- conflict resolution
- addictions
- Critical Incdient
- relationships
- parenting
- depression & anxiety
- work/home stress
- PTSD Interventions



Our Website

For More Information

We encourage you to visit our website for detailed information on our services.

We provide 24/7 coverage for **emergency and trauma services**, ***dependent on availability due to service demands***, and all calls are returned within 3 hours of initial contact.

About Us

As a practicing social worker for approx. 30 years, Craig Maguire brings a unique and diverse background of child welfare, addictions, victim services, and conflict resolution/mediation experiences in a professional and comprehensive services package - designed to meet the expressed and diverse mental health needs of individuals and families.

Impressions

Craig Maguire, *BA, RSW, BCCSW, CASW*
Registered Social Worker/Therapist

Building Healthy Communities

LOCALLY OWNED

THE CHAMBER.
GREATER VICTORIA CHAMBER OF COMMERCE

PROUD AND ACTIVE COMMUNITY MEMBERS

Web: www.impressions-counselling.org
E-Mail: admin@impressions-counselling.org

Contact Us
for more information

(778) 557-8478

GET A FREE Consultation

Call us today for more information or visit our website!

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Victoria, BC V9B 5S4

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admin@impressions-counselling.org

NAME: _____

GROUP: _____

GROUP INTAKE ASSESSMENT

ON-LINE GROUP PROGRAM - GENERAL INTAKE FORM

APPLICATION PACKAGE — ***PROTECTED B DOCUMENT***

This form and its contents are Protected, when completed, under the Health Services Act of Canada

This form is a generalized intake assessment and case management data collection system for general counselling services for individuals - online groups.

NAME: _____ **TODAY'S DATE:** _____

LEGAL NAME: _____ *(if different from above)*

ADDRESS: _____ **GENDER:** M ☐ F ☐

_____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

BIRTHDATE: _____ **CURRENT AGE:** _____

IF YOU ARE 17 YEARS OF AGE OR YOUNGER, YOU REQUIRE THE CONSENT OF AN AUTHORIZED PARENT OR GUARDIAN TO CONSENT TO YOUR ON-LINE COUNSELLING SERVICES. SERVICES CANNOT BE PROVIDED WITHOUT THIS REQUIRED PARENTAL CONSENT.

PLEASE INDICATE YOUR CATEGORY BELOW:

YOUTH (10 TO 12 YEARS)	☐	*- Please complete below*
ADOLESCENT (13 TO 17 YEARS)	☐	*- Please complete below*
ADULT (18+ YEARS)	☐	*- Please skip to next section*
SENIOR (60+ YEARS)	☐	*- Please skip to next section*

PARENTAL AUTHORIZATION

I, _____ am the legal parent/guardian of the applicant identified on this on-line individual counselling services intake Agreement. I am fully aware of this request for counselling services and have consulted with this youth/adolescent to ensure that they are comfortable and satisfactorily informed to engage in this service. I hereby provide my authorization and full consent for:

_____

to participate in on-line counselling services with IMPRESSIONS Family Counselling Services Inc. I further acknowledge and accept the Conditions of this Agreement and have read and fully understand and accept responsibility for full compliance to the Terms of Service outlined in this Agreement.

PARENT NAME: _____ **PARENT BIRTHDATE:** _____ **PARENT PHONE:** _____

PARENT SIGNATURE: _____ **DATE OF SIGNATURE:** _____

PARTICIPANT SIGNATURE: _____

DATE OF SIGNATURE: _____

IMPORTANT

impressions inc. Family Counselling Services

Consent to Release Medical Information

Pursuant to the Personal Health Information Protection Act, 2004

I, the undersigned patient, hereby authorize ***IMPRESSIONS* Family Counselling Services**, and its representatives, to release/disclose ***and/or*** receive/accept my personal health information consisting of:

clinical notes, assessment records and results, diagnosis and treatment plan(s), consultation reports, progress reports and,

other: *please specify*

as deemed necessary and/or appropriate for the assessment, provisions and/or maintenance of health-related services.

with the following individual/organization/entity:

Organization Name *Contact Person* *Relationship to Patient* *Contact Phone No.*

PATIENT SURNAME	FIRST NAME	DATE OF BIRTH (DD/MM/YYYY)	
HOME ADDRESS		HOME PHONE NUMBER (optional)	
CITY		PROVINCE	POSTAL CODE

Acknowledgement and Consent Statement

I consent and authorize my attending Mental Health Therapist who has records, knowledge or information regarding my health/medical conditions to release and/ or receive such health/medical records/information to the individual/organization/ entity identifed above for the purposes stated.

I understand why I have been asked to authorize the disclosure of this information, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

Effective Date: This consent will be valid for one year from this date:

Therapist Name (please print)

IMPRESSIONS Family Counselling Services Inc.

NAME OF FACILITY/CLINIC OR ADDRESS

(866)708-3501 TOLL FREE

PHONE NUMBER (if available)

____ / ____ / ____

YYYY MM DD

Signature of patient, or representative, if patient is incapable of signing or making a personal decision.

Representative: If signed by representative, describe the relationship or authority (for example parent, spouse, legal guardian, personal directive, power of attorney)

Name of person signing above (please print)

Name of representative signing above (please print)

Witness Name (please print)

Witness Signature

RETURN TO: IMPRESSIONS Family Counselling Services Inc.
P.O.BOX 27002
VICTORIA, BC
V9B 5S4
CANADA

NOTES:

- IMPRESSIONS Family Counselling Services will not accept incomplete consent forms.
- This consent is obtained in accordance with section 34 of the *Health Information Act (Alberta)*, sections 7, 8 and 9 of *Personal Information Protection Act (Alberta)* and section 5 of the *Personal Information Protection and Electronic Documents Act (Canada)*.
- I understand I may revoke my consent at anytime but should I do so, this Agreement is immediately terminated.
- A separate consent form is mandatory for each contact required.

INFORMED CONSENT AUTHORIZATION GRANTED BY PATIENT OR PARENT/GUARDIAN

Child /Adolescent Informed Consent

The purpose of this form is to share some important principles, which guide IMPRESSIONS FCS INC. (IFCS) process, so that your decision to place your child or adolescent into counselling can be based on accurate, informed expectations. Please read this carefully and feel free to ask any questions about what you have read or to have further clarification. Informed consent is the parent's and/or the child or adolescent's full and active participation in decisions that affect them and freedom of choice based on the information shared. It is a continuous process throughout the counselling relationship.

Counsellors who work with children and adolescents have the difficult task of protecting the minor's right to privacy while at the same time respecting the parent's or guardian's right to information. Therapy is most effective when a trusting relationship exists between the counsellor and the child/adolescent. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed in detail. Upon completing the 8 weeks of your child's group therapy, we will review, in general, what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

Counselling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of one's life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, counselling has been shown to have benefits for individuals who go through it. Therapy can lead to better relationships, solutions to specific problems, significant reductions in feelings of distress and improved self-esteem. However, there are no guarantees of what they will experience. Counselling is a personal exploration and may lead to major changes in life perspectives and decisions. Together you, your child and IFCS will work to achieve the best possible results for him/her.

If we encounter each other outside of the office or in the community...

It may happen that therapist from IFCS run into each other outside of the office context and within the community, perhaps at a local grocery store or a function of some sort. It might be important to consider this so that you / your family can feel more comfortable in what will happen. IFCS therapists will not approach a child, adolescent or parent[s] to greet them, or to recognize them or address them in any way. We will maintain the full confidentiality of a person's involvement with us by proceeding as if they are not known to any therapist, unless

they choose otherwise by acknowledging a member of IFCS. This isn't to be unfriendly, but to ensure that you do not have to feel anxious about someone concluding that a therapist might know you because you visit IFCS. This will be so, unless you agree otherwise during your discussion with your therapist at IFCS.

Confidentiality:

In general, one of the most important rights the person seeking counselling has involves confidentiality. Information revealed by a client during counselling will be kept strictly confidential and will not be revealed to any other person or agency without written permission, with the following exceptions:

We may need to consult with other colleagues from time to time in order to gain assistance and insight in providing quality and helpful service. In order to maintain professionalism, we may also seek supervision by other counsellors. Regardless of the situation, every effort will be made to retain as much confidentiality of the client as possible.

Confidentiality has some legal limits as well. There are situations where IFCS can be required to reveal information obtained during therapy to another person or agency without the parent or child's permission. These situations involve danger to self, danger to others, and child abuse. In addition, IFCS notes on sessions can be subpoenaed in a court of law.

The parents agree that in the event custody of, or visitation with, the child is contested in a legal proceeding, neither the parents nor their attorneys will require IFCS therapists to testify at any of the proceedings, because to do so would hurt the child's treatment, because the therapist's role is a therapeutic relationship and not an evaluation of parent capacity. Furthermore, other forensic professionals would be better able and more appropriate to conduct any necessary evaluation. Because of these limitations, IFCS therapist's also will not be able to give any opinion regarding custody, visitation or any other legal issue.

Termination of therapy:

Each parent agrees that he or she will not end the child/ adolescent's therapy without the agreement of the other parent, and that if we disagree about the child/adolescent continuing in therapy, we will try to come to an arrangement, by counselling if necessary, before ending the child's therapy. We each agree to cooperate with the treatment plan of the therapist for the child and understand that without mutual cooperation, the therapist may not be able to act in the child/ adolescent's best interests and may have to end therapy.

By signing below the parents/ guardians are indicating that they have read and understood this agreement, that they give consent to the therapists treatment of the child/adolescent, and that they have the proper legal status to give consent to therapy for the child/adolescent.

Late on-line group arrivals:

As the parents/guardian you understand that if your child is late arriving at the scheduled on-line group session, beyond 15 minutes of the scheduled start time, that they will not be granted access to the group scheduled on that date. You are nonetheless responsible to pay the counsellor the full fee that would be charged for the total time of that appointment and all advance payments received are non-refundable.

Cancellation:

Please contact the office if you discover that your child/adolescent will not be able to keep an appointment already scheduled. IFCS require 24 hours-notice for cancellations. You will be charged $65.00 fee for the missed appointment, without providing advanced notice.

Emergency:

If there is an emergency between sessions, please contact your family physician, the local hospital emergency room, or **911** emergency services immediately**.**

Obtaining Parental Acknowledgment and Consent:

(please circle one)

Parents share joint custody ☐

One parent has sole custody ☐

1)Parent contact information:

Name:_____

Address: _____

_____

Telephone/Cell _____

2)Parent contact information:

Name:_____

Address:_____

_____

Telephone/Cell _____

By your signature below, you are indicating that you read and understood this consent form and that any questions you had about this consent form were answered to your satisfaction.

I/we consent that my son/daughter/child under the age of 18,

_____

(enter name of child)

may be treated as a client by any therapist under IMPRESSIONS FAMILY COUNSELLING SERVICES INC. (IFCS)

1. Parent name (please print):_____

   Signature: _____

   Date:_____

2) Parent name (please print):_____

   Signature: _____

   Date:_____

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Victoria, BC V9B 5S4

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YOUR RIGHTS AND RESPONSIBILITIES

PLEASE TAKE A BRIEF MOMENT AND REVIEW YOUR RIGHTS AND RESPONSIBILITIES

- You have the right to good treatment – to be treated nicely, no matter what your state of mind or condition.
- You have the right to be treated respectfully and not be neglected, abused, have your feelings hurt or be yelled at.
- You have the right to privacy.
- You have the right not to be exploited. That is, your provider cannot use you or your case for his or her own personal gain.
- You have the right to treatment no matter your age, race, sex, religion, ethnic background or handicap. If this provider cannot treat you, for any reason, you have the right to be referred to a provider who can and will treat you.
- You have the right to know how your problems will be treated and what you can expect during the term of your treatment.
- You have the right to make choices throughout your counselling treatment plan.
- You have the right to refuse counselling intervention. If you say, “no” to a particular treatment, you have the right to know what might happen with or without the treatment.
- You have the right to have your records treated confidentially, and in accordance with the applicable Provincial and Federal Laws.
- If you have questions or do not agree with your treatment plan, you should discuss it with your provider.
- You have the responsibility to be on time for all appointments with your provider.
- You have the responsibility to give information to your provider if it’s needed for your care.
- You have the responsibility to read and ask questions about your provider’s terms and conditions of service prior to acknowledging and accepting these terms, as outlined in this Agreement, and to provide your authorization/consent for treatment with informed consent and full understanding of the Agreement terms.

PLEASE VISIT OUR WEBSITE FOR A COMPREHENSIVE REVIEW OF OUR CORPORATE TERMS OF SERVICE AND POLICIES.

impressions inc. Family Counselling Services

GROUP INTAKE ASSESSMENT

ON-LINE GROUP PROGRAM - GENERAL INTAKE FORM

APPLICATION PACKAGE — *PROTECTED B DOCUMENT*

GENERAL INTAKE ASSESSMENT PROFILE

PARTICIPANT NAME: _____

INSURANCE INFORMATION

Primary Health Insurance: _____ **Subscriber Name:** _____

Relationship to Subscriber: _____ **Subscriber Date of Birth:** _____

ID Number: _____ **Group/Policy Number:** _____

CURRENT TELEPHONE NUMBERS

Home: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

Work: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

Cell: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

MARITAL STATUS

- ☐ **Single**
- ☐ **Divorced**
- ☐ **Living as Married (_____ years)**
- ☐ **Married (_____ years)**
- ☐ **Separated (_____ years)**
- ☐ **Widowed (_____ years)**

EMPLOYMENT STATUS

Are you employed? Yes ☐ No ☐

Employer Name: _____

Years with Employer: _____

Are you using EAP? Yes ☐ No ☐

Job Title: _____

Stress level of this position: ☐ Low ☐ Med ☐ High

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Phone (Home): ( )_____ **Phone (Cell):** ( )_____

Relationship to you: _____

RERERENT

By whom were you referred or how did you learn of our organization and services?

_____

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem you are experiencing: _____

_____

_____

_____

Please check all of the behaviours and symptoms that you consider problematic:

☐ Distractibility	☐ Loss of pleasure/interest	☐ Guilt/shame
☐ Hyperactivity	☐ Hopelessness	☐ Fatigue
☐ Impulsivity	☐ Thoughts of death	☐ Change in appetite
☐ Boredom	☐ Self-harm behaviours	☐ Lack of motivation
☐ Poor memory/confusion	☐ Crying spells	☐ Withdrawal from people
☐ Seasonal mood changes	☐ Loneliness	☐ Anxiety/worry
☐ Sadness/depression	☐ Low self-worth	☐ Panic attacks

- ☐ Fear away from home
- ☐ Compulsive behaviour
- ☐ Homicidal thoughts
- ☐ Visual hallucinations
- ☐ Excessive energy
- ☐ Nightmares
- ☐ Computer addiction
- ☐ Sexual problems
- ☐ Alcohol/drug use
- ☐ Social discomfort
- ☐ Aggression/fights
- ☐ Flashbacks
- ☐ Suspicion/paranoia
- ☐ Wide mood swings
- ☐ Eating problems
- ☐ Problems with pornography
- ☐ Relationship problems
- ☐ Recurring, disturbing memories
- ☐ Obsessive thoughts
- ☐ Irritability/anger
- ☐ Hearing voices
- ☐ Racing thoughts
- ☐ Sleep problems
- ☐ Gambling problems
- ☐ Parenting problems
- ☐ Work/school problems
- ☐ Other: _____

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational Activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

Yes ☐ No ☐ Have you ever had thoughts, made statements or attempted to hurt yourself? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you ever had thoughts, made statements or attempted to hurt someone else? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you gambled in the past 6 months? If so, please indicate below:

Yes ☐ No ☐ Have you ever felt the need to bet more and more money?

Yes ☐ No ☐ Have you ever had to lie to people important to you about how much you gambled?

FAMILY AND DEVELOPMENTAL HISTORY

RELATIONSHIP	NAME	AGE	QUALITY OF RELATIONSHIP
Mother			
Father			
Step-Mother			
Step-Father			
Siblings			
Spouse/partner			
Children			

FAMILY MENTAL HEALTH PROBLEMS	WHO?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Other:	

Please check if you have experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Violence in the home
- ☐ Parent substance abuse
- ☐ Place a child for adoption
- ☐ Crime Victim
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Loss of a loved one
- ☐ Workplace violence
- ☐ Other trauma experience:

_____

- ☐ Neglect
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Parent illness
- ☐ Homelessness
- ☐ Financial issues
- ☐ Teen pregnancy
- ☐ Military Service

PREVIOUS MENTAL HEALTH TREATMENT

YES	NO	TREATMENT TYPE	WHEN?	PROVIDER/ PROGRAM	REASON FOR TREATMENT
☐	☐	Outpatient Counselling			
☐	☐	Medication (mental health)			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			
☐	☐	Self-help/Support Groups			

MEDICAL INFORMATION

Have you experienced any of the following medical conditions during your lifetime?

- ☐ Allergies
- ☐ Chronic pain
- ☐ Dizziness/fainting
- ☐ High fevers
- ☐ Sexually transmitted disease
- ☐ Asthma
- ☐ Surgery
- ☐ Meningitis
- ☐ Diabetes
- ☐ Abortion
- ☐ Headaches
- ☐ Serious accident
- ☐ Seizures
- ☐ Hearing problems
- ☐ Sleep disorder
- ☐ Stomach aches
- ☐ Head injury
- ☐ Vision problems
- ☐ Miscarriage
- ☐ Other: _____

Please list any CURRENT health concerns: _____

_____

Please list any current prescription medications: ☐ None

_____

_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network *(Check all that apply)*:

- ☐ Family
- ☐ Neighbours
- ☐ Friends
- ☐ Students
- ☐ Support/Self-help Group
- ☐ Co-workers
- ☐ Community Group
- ☐ Religious/Spiritual Centre

To which cultural or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

_____

How important are spiritual matters to you? Not at all ☐ Little ☐ Somewhat ☐ Very Much ☐

Please describe your strengths, skills and talents: _____

Describe any special areas of interest or hobbies (ie. books, physical fitness, etc.): _____

_____

EDUCATION

Are you currently attending school? ☐ Yes ☐ No

☐ High School Graduate	OR	☐ GED	Year _____
☐ College Diploma	Year _____		Major area of study _____
☐ Undergraduate Degree	Year _____		Major area of study _____
☐ Graduate Degree	Year _____		Major area of study _____

MILITARY SERVICE

Have you been/are you currently in the military? Yes ☐ No ☐ *(*If no, skip this section)*

Branch: _____

Date of Discharge: _____

Type of Discharge: _____

Rank: _____

Were you in combat? ☐ Yes ☐ No

LEGAL

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain:

_____

_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain: _____

_____

INFORMED CONSENT – TERMS OF SERVICE AGREEMENT

In addition to, and in conjunction with, our Corporate Terms of Service, the following terms and conditions constitute the user's informed consent and agreement with the following terms of this Service Agreement:

1. The client will be charged the established rate fee for 1.0 hour of on-line counselling services for the date and time specified. Clients who attend their appointment late will forfeit any time lost due to their tardiness and the scheduled appointment will end at the original time specified in the appointment booking, at the original rate. Please note that clients who are in excess of 15 minutes late for their confirmed scheduled appointment will forfeit their entire appointment and be subject to the CANCELLATION/NO SHOW policy.
2. Clients who do not provide sufficient notice of cancellation or provide no notice of cancellation for their confirmed on-line appointments will be charged the full regular fee of $65.00 dollars for their missed appointment. Please note that clients who continue to miss appointments without sufficient notice will be subject to our refusal of services, as per our Terms of Service, at our discretion.
3. As per Provincial and Federal Licensing requirements, counselling services are available to Canadian citizens only who reside in Provincial territories where the therapist is duly authorized to practice. These Provinces currently consist of: British Columbia. We regret that we are unable to provide professional counselling services to anyone outside of this geographical regions.
4. The client acknowledges and accepts the Terms and Conditions and has been provided sufficient opportunity to review IMPRESSIONS FCS INC. corporate Terms of Service via our on-line website and acknowledges their full acceptance and compliance with all terms and conditions represented. The client further acknowledges and accepts they have been provided with satisfactory responses to their submitted enquries and holds IMPRESSIONS FCS INC. harmless for any miscommunications, misunderstandings or lack of sufficient and accurate information beyond the control and influence of IMPRESSIONS FCS INC.

CONSENTS/AUTHORIZATIONS

PLEASE INITIAL

Informed Consent
I have read and fully understand the Terms of Service as provided to me by IMPRESSIONS FCS INC. I consent to receiving mental health counselling services with IMPRESSIONS FCS INC. and am satisfied my questions regarding these services have been answered to my full understanding and acceptance.

Terms of Service - Rights & Responsibilities
I have reviewed and understand my rights and responsibilities for receiving counselling services with IMPRESSIONS FCS INC. This includes complaints, fees, no-show/cancellation policies and my rights. A copy of these rights and responsibilities are available to me on the IMPRESSIONS website. All questions have been answered to my satisfaction.

Notice of Privacy Practices
I have reviewed IMPRESSIONS FCS INC. privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have access to a copy of these policies via the IMPRESSIONS website. I understand that IMPRESSIONS FCS INC. will share basic information with my primary care provider unless I ask to "restrict" this disclosure.

Financial
I have reviewed and understand my responsibility to provide advance payment for services selected, for the amount indicated.
If I cancel a scheduled appointment without providing 24 hours advance notice, or do not show up for a scheduled on-line appointment, my advance payment will not be reimbursed of credited. I or my parent/guardian accept "financial guarantor" of my patient case file, meaning I will be responsible for all payments related to my requested services.

On-line Group Session Recording
I understand and accept the purposes for mandatory video/audio recording of all on-line counselling sessions as a measure of clinical evaluative processes in maximizing my therapist's ability to review and assess my treatment outcomes. I provide my authorized consent for any and all recording of my counselling sessions and understand I may revoke this consent, in writing, at any time. I understand and accept that IMPRESSIONS FCS INC. reserves the right to refuse services if my consent to record my counselling sessions is revoked.

CLIENT NAME: _____ **CLIENT BIRTHDATE:** _____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other _____

Parent/Guardian Signature: _____ **By signing your name here, you consent to your youth receiving counselling services.*

CLIENT SIGNATURE: _____ SIGN HERE **DATE:** _____

THERAPIST NOTES: _____

CASEFILE STATUS: ☐ **Urgent/Emergency** ☐ **Regular** **Referral Source:** _____

RECOMMENDATIONS RESULTING FROM INTAKE: _____

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where your therapist is permitted or required to disclose information without either your consent or authorization. If such a situation arises, your therapist will limit their disclosure to what is necessary. Reasons they may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. Your therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if they receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order your therapist to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, your therapist may be required to provide it for them.
3. If a client files a complaint or lawsuit against your therapist, they may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and your therapist is providing necessary treatment related to that claim, they must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. IMPRESSIONS FCS INC. may disclose the minimum necessary health information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which your therapist is legally obligated to take actions, which they believe are necessary to attempt to protect others from harm, and they may have to reveal some information about a client's treatment:

1. If they know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires

that I file a report with Child Protective Services. Once such a report is filed, your therapist may be required to provide additional information.

2. If they know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that your therapist file a report with Child Protective Services. Once such a report is filed, they may be required to provide additional information.
3. If they believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, your therapist may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment–*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment***– We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations***– We may use and disclose your health information within IMPRESSIONS FCS INC. as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Client's Rights:

- ***Right to Confidentiality***– You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions***–You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations***–You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy***–You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $2.50 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.
- ***Right to Amend***– If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, your therapist will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with your therapist. If you wish, Creative Healing will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with your therapist at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with your therapist in session before terminating or at least contact them by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI. They reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we am required to abide by the terms currently in effect. If we revise practice policies and procedures, we will provide you with a revised notice in office during session.

COMPLAINTS

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision they made about access to your records, you may contact IMPRESSIONS FCS INC., or the BC College of Registered Social Workers.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed Name of Client	*Signature of Client*	*Date*