

INFORMED CONSENT & PRACTICE AGREEMENT



300 Coldwater Rd, Orillia, ON

All information is confidential and protected under application privacy laws.

1. CLIENT INFORMATION

Full Legal Name (First, Middle, Last)

Date

This agreement explains the nature of psychotherapy, confidentiality and its limits, privacy practices, communication, fees, cancellations, professional boundaries, and other practice policies. Consent is an ongoing process; you may ask questions at any time.

1. NATURE OF COUNSELLING

Counselling is a collaborative process intended to support emotional, relational, behavioural, psychological, and/or life concerns. Therapy may involve exploration of thoughts, emotions, relationships and experiences; psychoeducation; skills; therapeutic exercises; goal setting; and discussion of patterns. Potential benefits include increased insight, coping and improved functioning. Discussing difficult experiences can sometimes temporarily increase emotional distress. No particular outcome can be guaranteed.

2. CLIENT RIGHTS & CONSENT

- ☐ I may ask questions about treatment.
- ☐ I may participate in treatment goals.
- ☐ I may decline an intervention.
- ☐ I may withdraw consent to treatment.
- ☐ I may raise concerns about therapy.
- ☐ I may request a referral where appropriate.
- ☐ I understand therapy does not guarantee a specific outcome.

3. CONFIDENTIALITY & LIMITS

Information shared in counselling is generally confidential. Personal health information will be protected in accordance with applicable Ontario privacy law and professional requirements. Confidentiality may be limited where disclosure is required or permitted by law, including certain serious safety circumstances, child-protection obligations, legal proceedings or regulatory requirements. When reasonably possible, relevant limits will be explained to you.

4. RECORDS & PERSONAL HEALTH INFORMATION

A clinical record will be maintained for services provided. It may include identifying information, presenting concerns, assessment information, goals, progress notes, correspondence, billing information, consent documentation, and other information reasonably necessary for care. Records will be safeguarded and retained according to applicable law and professional requirements. You may have rights to access or request correction of your personal health information, subject to applicable law.

5. COMMUNICATION & ELECTRONIC TECHNOLOGY

Routine communication may occur by telephone, email, text, or a client portal for scheduling, reminders, billing and administrative matters. Electronic communication carries privacy and security risks. Therapy should not normally be conducted through email or text. Please do not send urgent or crisis information electronically.

6. VIRTUAL COUNSELLING

If virtual counselling is used, technology may fail or be interrupted and there are privacy risks associated with electronic communication and internet connections. Clients should participate from a reasonably private location and not while driving.

☐ I consent to virtual counselling when offered. ☐ I do not consent.

7. AI-ASSISTED DOCUMENTATION

Emmanuel uses an AI-assisted transcription/documentation tool through a protected software. The AI-assisted transcription/documentation tool places reasonable safeguards to protect information. I may decline the use of AI Scribe or withdraw my consent at any time, without affecting my access to counselling services or the quality of care I receive. If I decline, my therapist will document the session without using AI-assisted transcription.

- ☐ **Yes, I consent** to the use of AI-assisted transcription/documentation tool during my counselling sessions as described above.
- ☐ **No, I do not consent** to the use of AI-assisted transcription/documentation tool during my counselling sessions.

8. FEES, PAYMENT & CANCELLATIONS

Counselling is provided at no cost. A refundable \$50 cash deposit is collected at the beginning of counselling and held on file. The deposit will be returned at the conclusion of counselling, provided there are no outstanding charges related to missed appointments.

Cancellation/no-show policy: Appointments cancelled with less than 24 hours' notice, or missed appointments, may be charged \$50 (The deposit. Another deposit will be needed to resume therapy.)

9. COUPLES / FAMILY COUNSELLING

When more than one person participates, the therapist will explain how confidentiality will operate for the couple/family and how privately disclosed information will be handled. A separate couples/family agreement may be required before treatment begins.

10. DUAL RELATIONSHIP

I understand that, because counselling takes place within a church or setting, I may have a relationship with my therapist outside of the counselling relationship. This may include attending the same church, participating in church activities or ministry, sharing mutual acquaintances, or encountering one another in the community. I understand that this may constitute a dual relationship and that it may create additional considerations regarding professional boundaries, privacy, confidentiality, and the counselling relationship. My therapist will make reasonable efforts to maintain appropriate professional boundaries and protect my privacy and confidentiality. If we encounter one another outside of counselling, my therapist will not acknowledge me as a client or discuss our counselling relationship unless I initiate the interaction or there is another appropriate reason to do so. I understand that I may raise any concerns I have about boundaries or the impact of a dual relationship at any time. I also understand that I may choose to seek counselling from another therapist if I believe that the dual relationship may interfere with my comfort, privacy, or therapeutic relationship. By consenting to counselling, I acknowledge that I have been informed of the possibility of an overlapping or dual relationship and have had an opportunity to ask questions or express concerns.

11. CLIENT ACKNOWLEDGEMENT

- ☐ I have had an opportunity to ask questions.
- ☐ I understand the nature and purpose of counselling.
- ☐ I understand confidentiality and its limits.
- ☐ I understand fees and cancellation policy.
- ☐ I understand privacy and communication practices.
- ☐ I understand consent is ongoing and may be withdrawn.

Client Name

Client Signature

Date

Therapist Name

Therapist Signature

Date