

Claire M. Weiss, MA, RCC

INTAKE FORM

Thank you for your interest in Claire Weiss Counselling services. Please take a moment to review and complete the following information:

Today's Date: _____

Name: _____ Referred By: _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

Home Number: _____ Cell: _____ Work: _____

OK to leave a message? _____ Email Address: _____

Person to Contact In Case of Emergency

Name: _____ Phone: _____ Relationship: _____

Name of Family Doctor: _____ Phone: _____

Address of Family Doctor: _____

If under 19, Parent/Guardian(s) Name: _____ Phone: _____

Parent/Guardian Email: _____ Alt. Phone: _____

My signature below indicates that *I have read the attached Treatment Agreement* and that I understand and agree with the terms described.

Client Signature: _____ Date: _____

Counsellor Signature: _____ Date: _____

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Treatment Agreement

1. **Confidentiality:** What you share in your counselling sessions is confidential and cannot be released to anyone without your consent. The exception is if your records are subpoenaed by a court of law. The law also requires that I report all cases of child abuse, and danger to self or others, to the appropriate authorities. In addition, emails, texting, and cell phone conversations cannot be guaranteed as confidential.
2. **Client Responsibility:** Counselling is a collaborative process that involves making decisions regarding the pace of therapy and participation in tasks, exercises or procedures that may be recommended. It is your right and responsibility to fully participate in this process, which means that you may accept or reject any suggestions made and are free to fully discuss your decisions.
3. **Client Rights:** You have the right to ask about your therapist's qualifications, training, and background. You can request a referral to another therapist at any time.
4. **Clinical Supervision:** Your progress in therapy may be discussed, in an anonymous way, with my clinical supervisor. In this regard, I may ask to audio tape or video tape sessions from time to time. This is optional, and while the benefits of your therapy increase with additional supervision you may refuse or retract your consent at any time.
5. **Cancellation & Missed Appointments:** Many people wait for counselling and appreciate any openings that become available due to cancellations. Please be aware that when you schedule an appointment the full time is reserved for you. If the need to cancel should arise, it must be done with at least 24 hours notice. Otherwise, you will be charged the full fee for the session. If you are late for your appointment, it is not possible to make up the time at the end of the session. If I am running late, then your time will be made up at the end of the session.
6. **Payment & Structure of the Session:** Fees are charged on a per session basis at a rate of \$120.00. Individual sessions are 50 minutes in length, while couples sessions are 75 minutes in length. The actual time I devote to your case is often much longer and includes note-taking and reflection on the details of your case, as well as any research or consultation that may increase my understanding of your special issues.

Generally, clients pay at the beginning of the session and I issue a receipt for reimbursement by insurance and extended health coverage. Please note that it is your responsibility to ensure that my services will be covered by any extended health insurance you may hold. I accept the following forms of payment: cash, cheque, credit card, e-transfer, or paypal.

Please provide credit card information on the attached form so that charges can be applied to any missed appointments or late cancellations.

Please feel free to ask me if you have any questions about the information contained in this document.

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Credit Card Authorization and Consent Form

I, _____ hereby authorize
Claire Weiss to charge my credit card for session fees, missed appointments, and late
cancellations.

Type of Card Visa MasterCard Amex

Credit Card Number: _____

Expiration Date: _____

Name of Cardholder: _____

Credit Card billing address: _____

Total amount to be charged: 110.00 (CAD) Canadian Dollars

Authorized Signature of Cardholder _____

Signing this, I acknowledge the charges described hereon, assume full responsibility for
said charges and agree to honour and abide by the terms of payment. **I acknowledge and
accept the cancellation policies as stated in the Treatment Agreement document.**

Signature: _____

Date: _____