Cleidemar Teani, MA

Registered Psychotherapist

CRPO license #001329

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Welcome to my practice. This document presents essential information about my professional services and business policies. It contains summary information about the Personal Health Information Protection Act, a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although this document is long and somewhat complex, it is particularly important that you understand it. When you sign it, it will also represent an agreement between us. We can discuss any questions you have when you sign it or at any time in the future.

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described along this form.

The first or first two sessions will involve an informal evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include; when we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise.

Appointments will ordinarily be 50 minutes in duration, at a frequency and time we agree on. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, my policy is to collect the amount of your payment (unless we both agree that you were unable to attend due to circumstances beyond your control); also, adjustments to these policies have been made considering the COVID-19 protocol. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Consent for Psychotherapy Services

I, _____, hereby request and agree to participate in individual therapy with Cleidemar (Cleide) Teani, MA in Psychology, Registered Psychotherapist.

Personal Information:

First name: _____Last name: _____Date of birth: _____

Address: _____City: _____Province: ___Postal code: _____

Phone: (home)_____(work)_____(cell)_____

Email address: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship to you: _____

Physician's Name: _____

I understand that psychotherapy requires that I discuss my problems and difficulties with a psychotherapist, who will listen to me carefully, trying to provide a supportive and empathic setting.

The psychotherapist will not offer advice or solutions to my problems but will try to assist me in coming to the best solution for my situation.

I understand that psychotherapy is likely to help me, but this cannot be guaranteed, and the process might be painful at times; it has benefits and risks. It often leads to better relationships, more effective solution to problems and reduction of distress. But, as it involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings and may remember unpleasant memories.

I will be free to ask questions about the treatment process at any time as well as to terminate this agreement at any time.

I understand that by attending and participating in sessions, I am giving my consent for psychotherapy services.

Confidentiality/Limits of Confidentiality

I understand that all information regarding my treatment (including all verbal and/or written exchanges) will be kept confidential, except under the following circumstances and in each of

these circumstances, my psychotherapist will try to notify me of the need to break confidentiality:

_ if I indicate that there is imminent risk of harm to myself or others;

_ in case of apparent or suspect abuse of a child under 16, an elderly or disabled person;

_ if a known sexual perpetrator is in close contact with a child under 16;

_ if I report sexual abuse on the part of a health care professional;

_ if my records are subpoenaed by a court of law;

_ if the records of my psychotherapist are randomly audited by the College of Registered Psychotherapists of Ontario

I understand that to maintain my confidentiality, my psychotherapist will not initiate contact with me in any private or public setting outside of treatment. Rather, I can initiate any contact outside of therapy based on my level of comfort. I understand that it may be advisable not to initiate contact in the presence of others to maintain my confidentiality.

Fees for Service

I understand that the fee for service is $ 135.00 per session for individuals and $150.00 for couples and families. Payment is due at the end of each session, payable by electronic transference, cash, or personal cheque (made out to the order of "Cleidemar Teani"). I will be supplied with a receipt of payment for services, which I can submit to my insurance company for reimbursement if that is the case. My therapist is a participating provider for Medavie - Blue Cross, to which transactions are made online and with direct pay.

Contact

I understand that I can contact my psychotherapist, Cleidemar (Cleide) Teani, by email at cleidemarteani@gmail.com or by phone at 705-875-8783.

My signature indicates that I have read and understood the contents of this form, that I have had the opportunity to ask questions and these questions have been answered to my satisfaction, and that I freely agree to participate in psychotherapy.

Client Signature: _____ Date: _____