FERNIE COUNSELLING AND CONSULTING
Agreement for Services

Client: ____

Client:____
Address:

____

Phone: (Home) __________________(Work)_______________________ (cell) __________________

Child: _____________________________ D.O.B._______ Age: ____ M __ F__

PAYMENT FOR SERVICES RENDERED

Please read the following carefully and ask any you may have before signing this.
Payment is due at the time of services. I accept cash and checks only.
You will be expected to pay for each session at the time it is held, unless we agree otherwise. The fee is $130.00- $190.00 per session.
Cancellation policy: All clients will provide *Fernie Counselling & Consulting* with at least 24 hours notice of an appointment cancellation. If you cancel within 24 hours of your appointment, or if you fail to show, you will be responsible for the fee of the scheduled session.
Fernie Counselling and Consulting will not get involved in Custody Court because it is counterproductive to therapy.
If circumstances of unusual financial hardship exist, a negotiated payment plan of installments may be available.
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, *Fernie Counselling and Consulting* has the option of using legal means to secure the payment. If such legal action is necessary, its costs will be included in the claim.

FINANCIAL RESPONSIBILITY

I accept the financial responsibility for the charges incurred. I understand that payment is due at time of services. Any other arrangement must be approved by Cheryl Hulburd MSW RSW CP RPT EMDR CERTIFIED in advance.
*NO-SHOW AND CANCELLATIONS POLICY: Your visit has been reserved for you, therefore **24-hour notice is required for cancellations or you will be charged your full session fee amount. Please note that there will be a $25 for all duplicate receipts.**

Signed____________________________________Date_______

CONFIDENTIALITY

Although most information discussed in session is confidential, there are exceptions.
There is an obligation by law and professional ethics to report to appropriate agencies concerning issues of:

Child physical and sexual abuse-child protection concerns, criminal intent, potential danger to oneself or others (medical emergencies or threats of violence).

Information may also be subpoenaed by a court of law.
Please feel free to discuss any limitations or concerns regarding this issue of confidentiality.

Authorization for Release Of Information To Others

I hereby authorize Cheryl Hulburd, to consult or share in formation as needed for the purpose of providing services to the above named client. I have indicated with initials those programs/individuals with whom information may be shared.

Client's Initials

_____ Family Physician____ _(name)

_____ Psychologist/psychiatrist____ (name)

_____ MCFD Social Worker ____(name)

_____Teacher ____ (name)

_____Social work/counselor Supervision_________________________________ (name)

_____Other (please specify) ____ (name)

Other specific requests regarding information sharing: ______________________________

____

I hereby give my consent for sharing information for the purpose of supervision/consultation. I am also aware that information must be reported to the appropriate agencies any issues concerning child abuse, intent to harm, or intent to commit suicide. I am also aware that Cheryl Hulburd may be subpoenaed by a court of law to provide information.
This consent will expire upon termination of services after one year, or upon my request which ever comes first.

Release For Videotaping and Recording

I understand and give my permission to Cheryl Hulburd, MSW, RSW, CP, RPT, EMDR CERTIFIED for videotaping and /or recording the therapeutic sessions of my child(ren). This information will be used solely for supervision consultation.

Signed: _________________________________Date: __________

Alert and Medical Information

Emergency Contact ________________________ Phone________

Client's Physician__________________________ Phone________

Allergies:
Chronic Medical Conditions:
Regular Medications:
Physical Limitations:
Behavioral Concerns (eg; Suicide, physical aggression, substance abuse):

Other:

Signed: ___________________________(Parent/ Guardian) Date:__________

__________________________ (Clinical Social Worker) Date:__________

Plan for Service:

On a scale of 1-10, please circle your current functioning. 1 2 3 4 5 6 7 8 9 10

What is the presenting problem?

Goals (specific changes to be made)

____________________________ ___________________________

____________________________ ___________________________

____________________________ ___________________________

DISCLOSURE STATEMENT

I am a master's level Social Worker , a (RSW) Registered Social Worker in the province of British Columbia and a BC Family Law Mediator. AS well , I a an (RPT) ,Registered Play Therapist in the U.S.,and a (CPT), Certified Play Therapist in Canada. I am a certified EMDR Therapist with EMDR Canada and am a member of (EMDRIA) Eye Movement Desensitization and Reprocessing International Association. I am a private practitioner at Fernie Counselling and Consulting and work with children, youth, adults, couples, and families. Additionally I am a certified Family Law Mediator.

Over the years I have developed several specialties. One of those is working with trauma victims, especially with survivors of any kind of childhood abuse. Some of the techniques I use are EMDR,Guided Imagery, Free Writing, Therapeutic Drawing, Art Therapy, Sand Tray Therapy, Workbook pages and Therapeutic Readings. Another specialty of mine is Undirected Play Therapy. However, like most clinicians, I have also developed an eclectic style that is adaptable for the many concerns that come with my diverse clientele.

A "good fit" in the therapeutic relationship is important to me. Therefore, if you feel that counselling is not working out for you, or that you would prefer to terminate the therapy and try another counselor, PLEASE LET ME KNOW!

Feel free to discuss any questions about your therapy with me that may arise during your treatment.

Thank you,

Cheryl Hulburd MSW RSW CP RPT EMDR CERTIFIED

CLIENT AGREEMENT

I, __________________________________ give consent to be evaluated and treated by Cheryl Hulburd MSW RSW CP RPT EMDR CERTIFIED.I understand that I may withdraw my consent for treatment in writing at any time.

I understand the above policy.

Signed_______________________________________ Date________

Witnessed____________________________________Date_________