AwakeningCounselling
connecting deeply for peace of mind
Business: 416.418.2678
Email: info@awakeningcounselling.ca
Website: www.awakeningcounselling.ca

Consent for Services

Awakening Counselling Services provides services in a private practice setting for businesses, agencies, youth, families, adults and members of the transgendered community. At *Awakening Counselling Services*, we seek to empower, strengthen, and educate individuals to achieve internal and external wellness by providing a holistic counselling and consulting approach.

To help you better understand our process, services and qualifications, please review this form: Consent for Services. If you agree to participate, you may also wish to sign a Consent for Disclosure form to communicate with other professionals and others who may be helpful to the process. To support a holistic care environment, collaboration between service providers and others you deem appropriate may occur to best support your outcomes. In addition, participation in the intake process and questionnaire will help develop a greater assessment of your experiences and best areas for intervention.

Clinical Director and Founder

Celine Williams-Tracey, Clinical Director and Founder of *Awakening Counselling Services* possess a Masters of Social Work degree. In addition, she is a registered Social Worker with the Ontario College of Social Workers and Social Service Workers (OCSWSSW) and a member of the Ontario Association of Social Workers (OASW). As a member of these associations, we are bound to the laws and ethical requirements as stated and found on their website. In addition, her focus has been on trauma, violence within interpersonal and intimate partner relationships, group facilitation, treatment of depression and anxiety, sexual abuse and sexual assault. To find out more information, please visit: www.awakeningcounselling.ca.

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General Practice and Approach

At *Awakening Counselling Services*, we provide a client centered approach to meeting the clients' individual needs. I believe therapy is a collaborative process between the client and therapist, and also with family, legal guardians, caregivers and more. Therapy can be successful with your hard work, energy and courage. The practice utilizes a variety of counselling approaches such as Trauma Counselling, Cognitive Behaviour Therapy, Dialectical Behavior Therapy, Solution-Focused Counselling, Motivational Interviewing, Narrative Therapy and group therapy, in general practice.

Client Rights and Responsibilities

As a client you have the right to be safe and secure within the sessions. Our clinicians seek to operate in a professional and ethical manner that follows the standards of the OCSWSSW and O.A.S.W. code of ethics. All records of therapy are kept in a file and available to you upon request, if deemed legal and of therapeutic value. You also have the right to be informed of the qualifications of the therapist working with you, as well as the right to decline or accept suggestions or therapeutic recommendations. We will remind of these rights and choices throughout our therapeutic relationship. We do not sell products directly, but if we make suggestions for books or other materials, it is your choice if you believe it would be helpful for you. Termination of the therapy relationship will be made by you or by a collaborative decision between us both. In the event, we decide to terminate therapy, we suggest three final sessions to develop a positive closure. As a client you have the responsibility to set and keep appointments on a regular basis as determined ahead of time. It is important for you to work with us around developing your treatment plans and check in with me in every session around goals. It is also important to keep us informed of your progress towards meeting your goals and to terminate your therapy relationship before entering into arrangements with another counselor.

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Fees and Insurance and Reimbursement

Awakening Counselling seeks to provide affordable services to individuals and families. We offer sliding scales for families and individuals who are economically disadvantaged. We offer group therapy and psycho-educational groups which also support access to counselling services. Some services may qualify as psychological services, or social work services, or EAP services under your extended health plan. Payments for fees are due at the end of the session. If you want to extend the counselling session by an additional 30 minutes, the sessional fee will reflect the additional time. It is required to provide a credit card number for a session that was cancelled within less of 48 hours. There are no late fees applied for overdue accounts, however, future service will require immediate payment. Please note that fees may be subject to change, but this will be discussed in advance with you and generally occur with advance notification within the year of the service.

Agreed upon fee: $_____/per 45 minutes to 60-minute session

Credit Card information: _____

Expiry date: _____ CV: _____

Postal Code: _____

Cancellation

When you are unable to make an appointment please notify Celine Williams-Tracey at Awakening Counselling Services 48 hours in advance. In the event that three sessions are missed, we will meet together to address solutions if therapy is to continue.

Emergencies

If you have an urgent situation, which you feel needs immediate support and we are not available by phone, please contact your local 911 system or go to the nearest emergency room. I will also provide you with a list of alternative telephone services.

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Records and Confidentiality

As a therapist we record notes and reports for your clinical records. You have rights to review your file upon your request verbally or in writing. Information may be shared amongst applicable Awakening Counselling staff if appropriate. Records are kept on site at the main office at all times. Once you terminate involvement or for a child/youth once they reach 18 years old, files must be maintained for at least seven years.

Most of the information is confidential, and will not be shared. Many times, clients will be able to take their art work and scrapbook home to bridge work done within sessions to their caregivers. There are some exceptions and they include:

a) the provision of a signed consent of a release of information,

b) If I believe you are going to hurt yourself, you are being hurt or are going to hurt another person,

c) If there is a disclosure in therapy of neglect, abuse or exploitation of a child under the age of 16, I am ordered by legislation to disclosure information,

d) Or if the court requests me to release information.

In addition, to adhere to professional standards and ethics need to discuss cases in formal supervision and also view video tapes of sessions which are used only for supervision, and will continue to meet this requirement by professional association. We will not use reference to full names to protect confidentiality to consultants or supervisors.

Complaints:

If at any time you would like to connect with the Clinical Director to address any concerns, please do not hesitate to contact at:

CLIENT'S ACKNOWLEDGEMENT: I have read and fully understand this agreement.

Client's Name: _____

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Client's Signature (if client is over 10 years old): _____

Date: _____

Legal Guardian/Parent: _____

Legal Guardian/Parent Signature: _____ **Date:** _____

Caregiver (if applicable): _____

Caregiver Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Intake Form:

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:

(Last) (First) (Middle Initial)

Name of Parent or Guardian (if the child is under 18 years old):

(Last) (First) (Middle Initial)

Birth Date (YYYY/MM/DAY): _____/_____/____ Age: _____

Gender: _____ Gender identified_____

Marital Status:

- Single
- Common Law Relationship
- Married
- Separated
- Divorced
- Widowed

Please list any children/age:

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Address: _____

(Street and Number)

(City) (Province) (Postal Code)

Home Phone: ( ) May we leave a message: ( ) Yes ( )No

Cell/Other Phone: ( ) May we leave a message: ( ) Yes ( ) No

E-mail: _____ May we email you?
□ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
_____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:
_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____
_____
Have you ever been prescribed psychiatric medication?
□Yes
□ No

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Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

_____

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□No

□ Yes

If yes, for approximately how long? _____

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6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□No
□ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□No
□ Yes
If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □No □ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

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Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □No □ Yes
If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____

2. Do you consider yourself to be spiritual or religious? □No □ Yes

If yes, describe your faith or belief:

_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____
_____

4. What do you consider to be some of your challenges?

_____
_____
_____
_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

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Service Inquiry:

What services are you seeking? Please advise or circle as many that are applicable:

Social Work

Sexual Abuse/Sexual Assault Counselling

Anxiety

Trauma

Depression

Self-esteem

VAW

Safety Planning

Transgender

What are your counselling goals?

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Client name: _____

Client Signature: _____ Date: _____

Therapist Name _____

Therapist Signature_____ Date: _____