Dandelion Consulting

jennifer van kessel and associates

Clinical Social Work Services for individuals, couples, families

Client Information Form

Client(s) Name(s):	
Date of Birth:	
Address:	
City:	**Postal Code:**
Phone (please include most effective number to reach, followed by next best options:	
Can a personal voice message be left on your phone(s)? Yes ☐ No ☐	
How were you referred to/ How did you find this service?	
Email Address: *Your email address is requested for the purpose of communicating scheduling changes or to send articles, exercises or other resources relevant to your care. Your email address will not be shared or used for any other purpose.*	

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Jennifer van Kessel, MSW, RSW
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Have you seen a counsellor or a psychotherapist before? What were your reasons at the time? What was helpful or unhelpful? Is there anything else you would like me to know about your past experiences?
What are your reasons for making this appointment?
Do you live with any long term or chronic health challenges? More recently, have you experienced significant illness or injuries?

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Do you take medication or supplements to support your mental health? Have you taken medication to support your mental health in the past? Please provide this information below.
Do you have other health care providers who are assisting you with emotional/ mental health concerns or relationship challenges? (Psychologist, spiritual leader, naturopathic doctor, psychiatrist, counsellor, guidance counsellor, etc.)
Are you a caregiver to others? Are there people in your life who rely on you for caregiving responsibilities? (ex: children, family members with illness or disability, etc)

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Are there any significant life events, such as losses, traumas or major life changes that you feel are important for me to know about before we meet? You do not need to provide significant details, but a few words can make me aware of them prior to your session.
Have you or anyone in your family ever experienced suicidal thoughts or a desire to end your life or to stop living? *If you are currently experiencing suicidal thoughts it is very important to tell someone. Please immediately visit your local emergency department or call 911.* *You may also reach out to the* ***Mobile Mental Health Crisis*** *line, a free-of-charge service for all Nova Scotians. This service is available* ***24 hours a day, 7 days a week.*** *902-429-8167 or 1-888-429-8167 (toll free).*

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Mental Health Services Agreement

Confidentiality

In providing you with services such as assessment and therapy, it is very important that you speak openly and honestly with your therapist in order to obtain the most benefit from the service. In order to encourage this openness, your therapist agrees to keep information that you share confidential. This means that the information you share in the course of assessment or therapy will not be shared with anyone without your consent. However, in order to ensure your safety, the safety of other vulnerable people and in other unique and unusual circumstances, an exception will be made to this confidentiality agreement. These are the situations that could require your therapist to share pertinent information with another party:

1) **If you present a risk of safety to yourself or others, this may be reported to others who can ensure or maintain your safety or the safety of others.**
2) **If you disclose knowledge that yourself or another person under the age of 19, a person who is unable for reasons of age or disability to self-protect may be at risk of abuse, this will be reported to the appropriate child or adult protection agency.**
3) **If you sign a release of information for a third party such as a physician, social worker, lawyer, insurance company etc., the information required by the third party will be released as requested.**
4) **If your file is subpoenaed by a judge.**

Information for Parents

If your child is receiving services, please understand that attempts to include you in treatment will be made. In most cases, however, your older child / youth retains the right to consent to treatment and can also refuse to accept treatment or engage in treatment that includes their family.

Your child or youth's therapist will ensure confidentiality, except in the situations described above. The benefit of maintaining confidentiality in this way is similar to the benefit obtained by adults who are ensured confidentiality by their therapist and assists in ensuring the best possible benefit from services.

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Other important information:

1) Your therapist is professionally required to keep records of contacts with you. These records will be kept in a secure location.
2) There is a fee for private mental health services. The rate for services is $150.00 for one session for an individual, $165 per couples session, and $175 per family session. Each session lasts for approximately 60 minutes. Methods of payment that we accept are: Visa, MasterCard and Debit. Exact cash will be taken if the other options are not available to you. Unless you have made other payment arrangements with your clinician or the administrative assistant, your payment will be taken at the beginning of the session and you will be provided with a receipt that may be used for reimbursement by your Health Insurance Plan. Your plan must cover psychotherapeutic services delivered by a social worker in order to claim these benefits.
3) Health plans will not cover the costs of missed appointments. You will be responsible for payment of missed appointments that are not cancelled within 24 hours of the scheduled time. If your appointment is on a Monday, cancellation of the appointment should be made by the end of the business day on Friday.
4) Your therapist is not able to provide emergency mental health services. In these cases, you should contact your family doctor, the emergency department of your hospital or call 911 for urgent/ emergent assistance or Mobile Mental Health Crisis Services at 902 429 8167 or 1 888 429 8167 (toll free).

I have read the information in this agreement and/or it has been reviewed with me. I understand the limits of confidentiality and the terms of receiving psychotherapeutic services. I accept these terms and limitations and consent to psychotherapeutic services.

Client Signature: ____

Signature of Guardian (If Applicable): ______________________________

Date: ____

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