New Life Counselling

Supporting Individual Wholeness and Healthy Relationships

In-Person and
Online Video Counselling (Teletherapy) Intake Form

PLEASE PRINT CLEARLY Today's Date

PERSONAL INFORMATION

PATIENT (S) **RESPONSIBLE PARTY (if youth is a minor)**

Date of Birth Gender Responsible Party's SIN

Address Address (if different)

City, Province Zip City, Province Zip

Email Email

Home Phone Home Phone (if different)

Work Phone Work Phone (if different)

Cell Phone Cell Phone (if different)

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self__ Spouse__ Child__ Other __N/A__

Relative or friend in case of emergency

Name Phone # Relationship

Source of referral Reason for referral

How did you hear about New Life Counselling?

Plese continue to the next page...

Therapist Use Only
Therapist Name _____
Dx _____
Special Instructions _____
_____

Location
☐ Calgary, Alberta

Billing
☐ Client Self Pay

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MEDICAL INFORMATION

1. **Patient Name**

Have you ever been treated for emotional difficulties before (When and Where?)

Physician: Name/Practice Address Phone

How is your general health now? Medications?

Are you presently being treated by a physician for any physical condition?

Have you had any serious illness or surgery? (List)

PLEASE MARK ALL THAT APPLY:

Anger	Grief	Paranoia
Anxiety	Guilt	Physical Aggression
Behavior Problems	Hallucinations	School/Work Problems
Changes in Appetite/Eating Habits	Hopelessness	Self Abusive Behavior
Criminal Activity	Hyperactivity	Sleep Disturbance
Decreased Energy	Impulsiveness	Somatic Complaints
Delusions	Interpersonal Conflicts	Suicidal Thoughts/Attempt
Depressed Mood	Irritability	Weight Gain
Disruption of Thought Process/Content	Manic	Weight Loss
Emotional/Physical/Sexual Trauma	Mood Swings	Worthlessness
Excessive Crying	Oppositional	Other (Specify)
Family Conflicts	Panic Attacks	

How could your life be better?

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 work?

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

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In-Office and Online Privacy Practices Form (Therapist and Client Copy)

A. INFORMED CONSENT FOR Individual, Couple, Family, EAP/EAFP: if applicable FOR ONLINE VIDEO COUNSELLING (TELETHERAPY)

Teletherapy refers to counselling services that remotely use telecommunications technologies, such as video conferencing or telephone. One of the benefits of Teletherapy is that the client and the therapist can engage in services without being in the same physical location. Although there are benefits of Teletherapy, there are some differences between face-to-face counselling and Teletherapy, as well as some risks. For example:

Because the Teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. As your therapist, I will take reasonable steps to ensure your privacy but it is important for you to make sure you find a private place for the session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in Teletherapy only while in a room or area where other people are not present and cannot overhear the conversation.

There are many ways that technology issues might impact Teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. Your therapist has a legal and ethical responsibility to protect all communications that are a part of Teletherapy, for example ensuring that the platform used is PHIPA compliant.

As your therapist, I have the right, at any time, to determine if Teletherapy is not appropriate for your situation. Should this be determined, I will provide you with referral information to other, more suitable, services.
Confidentiality: The extent of confidentiality and the exceptions to confidentiality outlined in Tacit Knowledge's Informed Consent document apply in Teletherapy;

The Teletherapy sessions shall not be recorded in any way. As your therapist, I will maintain a record of the session in the same way had the session been conducting face-to-face, in accordance with the policies/ethical standards outlined by both of my registering bodies - the CPCA and ACTA.

When engaging in a Teletherapy session, please also keep the following in mind:

- Ensure you are in a private, secure and appropriate location (free of distractions like family and pets if possible.)
- Verify ahead of time the best reception in your chosen location.
- Make sure your audio and video are working.
- Dress appropriately as you would for a session.
- Refrain from eating and/or smoking during the session as these can create communication challenges.
- Let the Therapist know your location. This is for your safety.

B. INFORMED CONSENT FOR Individual, Couple, Family, EAP/EAFP: if applicable for In-Office and Online Counselling

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified Counselling Therapist/Psychotherapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, medication referral, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 50-60 minutes. At the end of each appointment, you can discuss future appointments with your therapist.

Please continue to the next page…

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In-Office and Online Privacy Practices Form (Therapist and Client Copy) Continued…

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If you do not pay in full at the time of service. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash, check and e-transfers. Please make E-transfers out to "Jeremiah La Follette". E-transfers can be sent to **info@newlifecounselling.life**

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through New Life Counselling are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at New Life Counselling and is considered confidential within the office unless specified by you in writing. However, each therapist at New Life Counselling reserves the right to consult with a qualified registered therapist as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

☐ Yes	☐ No	I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions. I have also received a copy of this form.
☐ Yes	☐ No	I consent to the exchange of treatment information between NLC and my primary care physician.
☐ Yes	☐ No	I consent to the exchange of treatment information between NLC and _____.
☐ Yes	☐ No	I consent to telephone/online video counselling (Teletherapy).

FINANCIAL and INFORMED CONSENT

I understand that New Life Counselling is not responsible for submitting insurance. I will be given a receipt that I may submit to my insurance for possible reimbursement, understanding that not all insurance companies will cover this expense. As well, I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

Therapist Name/Office and Phone Number: Jeremiah La Follette (MCC, RPC), 403-690-8617, ACTA Member 1448, CPCA Member 3828

Patient: _____

_____	_____	_____
Digital Signature of Responsible Party	Printed Name	Date