Lorena Ibacache, M.A.
Counseling and Psychotherapy

356 MacLaren St.
Ottawa, ON, K2P 0M6

(613) 230-0998
lorena@ottawaholisticwellness.ca

CONFIDENTIAL CLIENT INFORMATION

Name: _____ Date of Birth (dd/mm/yy): _____

Address: _____

Telephone: (Home): _____ Is it okay to leave a message? Yes__ No__
(Office):_____ Is it okay to leave a message? Yes__ No__
(Cell):_____ Is it okay to leave a message? Yes__ No__

Email: _____ Is it okay to send an email? Yes__ No__

Emergency Contact Information:

Name: _____ Relationship: _____ Tel #: _____

Third Party Insurer: _____

INFORMED CONSENT

The purpose of this form is to share some principles and responsibilities that guide my counselling practice, so that your decision to proceed in working together can be based on accurate, informed expectations. It is meant to ensure your safety and keep clarity in the therapeutic process. Please read this carefully and feel free to ask any questions. Informed consent is a continuous process throughout the counselling relationship, and as client you have the right to refuse and/or withdraw from counselling/psychotherapy at any time.

Approach to Therapy

As a graduate of the Saint Paul University Master of Arts (M.A.) program in Counselling, Psychotherapy and Spirituality, my mandate is to provide you with the best confidential counselling services possible in a respectful, compassionate and professional manner. I use an integrative and holistic approach, combining client centered/emotion focused, systemic, narrative, and psychodynamic therapies, adapting them to your particular needs.

I assist my clients to understand and explore issues associated with depression, anxiety, relationship issues, trauma, stress, loss, grief, anger and self-esteem issues. My aim is to foster a safe, non-judgmental environment, enabling you to comfortably explore past and present experiences. I believe that every individual is able to shift present patterns that are causing them difficulty, and I focus on supporting my clients to feel empowered to make the changes they are seeking in their lives. I offer counselling services in English and Spanish.

Goals and Objectives

You will set your own therapeutic goals and objectives for us to work together.

Psychotherapy is done with the intention of healing issues that both the therapist feels they can successfully accomplish and the client decides to address. Psychotherapy may also bring deeper awareness and insight, solutions, understanding and coping of problems and reduce emotional and physical distress. As the client, you should be aware therapy requires the willingness to discuss and examine difficult issues and may result in experiencing strong and uncomfortable emotions, feeling challenged and the potential of feeling worse before you feel better. It is the ultimate decision of the client what will be addressed and as such, you will be asked to continually consent to sustained therapy. If at any time you feel uncomfortable or hesitant to engage in a specific issue or dialogue, please do not hesitate to let me know as soon as you are able.

If an emergency situation arises between our sessions, please call **911** immediately. I encourage you to bring your concerns to our regular therapy session.

Professional Ethics

Counselling and psychotherapy adheres to the highest standards of professional and ethical conduct. These guidelines are based on the standards established by the Code of Ethics of the College of Registered Psychotherapists of Ontario (CRPO) and the Code of Ethics of the Canadian Counselling and Psychotherapy Association (CCPA).

Confidentiality

Confidentiality is of utmost importance and is an integral part of counselling and psychotherapy. All information discussed in sessions will be kept confidential, with the exception of clinical supervision -when applicable- and in cases of specific legal and ethical limits (see below). Information is released *only* with the client written consent and *only* to those individuals in need of information in order to provide care to the client.

The following are exceptions or limits to confidentiality, as required by law:

- If there is an imminent danger of the client seriously hurting him/herself;
- If there is an imminent danger of the client seriously hurting someone else, the individual(s) at risk from harm will need to be alerted;
- If there is any indication that a child (under 16 years old) or an elderly person (over 65 years old) is at imminent risk from sexual, physical, emotional abuse and/or neglect;
- In some cases, a file could possibly be subpoenaed by the court or reviewed by a regulatory body;
- In the case where a client has been sexually abused and/or harassed by a health professional, a report must be made to the appropriate college/regulatory body.

Other Professionals

Keeping in mind your specific needs, at any time either part (client or therapist) may suggest that another mental health professional or type of therapy is indicated/preferred. In such case, an appropriate referral will take place. Also, if you are currently being seen by another mental health professional and would like us to consult with one another, we can only do so if you have given us both written consent.

Agreement on Fees

Counselling and psychotherapy fees are **$ _____ per session, plus HST ($ _____)**. Private insurance plans may cover all or part of my services as I am supervised by registered psychologist **Dr. Augustine Meier, Ph.D., C. Psych, (Reg. No. #1651)**. The responsibility is on the client to contact their respective insurer to verify if the services are covered, and it must be communicated at the **first** therapy session in order to ensure appropriate supervision.

Payments

Payment is due at the end of each session. Fees are payable by cash, debit or credit card. A receipt will be issued, and clients are required to submit receipts directly to their private insurance companies for reimbursement. *Please advise me in advance of any potential problems with full payment.*

Cancellation Policy

If it is necessary for you to cancel an appointment, please do so **48 hours** prior to your scheduled session. With the exception of emergencies, appointments that are missed, or are cancelled with less than 24 hours notice, will be charged at the regular fee. You can cancel your appointment online up to 48hrs prior at **ottawaholisticwellness.ca** or anytime by phone at **(613) 230-0998**.

Number and Length of Sessions

Clients are typically seen on a weekly basis and a typical session lasts **50 minutes**. The number and frequency of sessions varies according to each client's specific needs.

Record Keeping

I will keep information concerning your sessions in a confidential file. Once information is placed in a file, it must remain there. You have the right to see your file and can request to do so in writing. Clients may view files in the office only.

Length of Contract

This contract guarantees fees for one year only and expires after a twelve month period. Fees may be subject to change upon renewal. Signing of this contract does not commit any of the parties below to attendance of counselling/psychotherapy.

As a client you have the right to terminate therapy at any time. As therapist, I reserve the right to end the therapeutic relationship if, for example, I believe I cannot be successful in meeting your counselling needs, however a referral to an appropriate, regulated health care professional will be made whenever possible to ensure your continuity of care.

CONSENT FORM

1. **Request for Services**

I, _____ have read the information outlined in this document including the ethical issues of confidentiality and the limits to confidentiality. I understand these policies and have had an opportunity to discuss them with my therapist.
I am requesting the following service:

(Please initial): Individual Counselling/Psychotherapy _____

2. **Consent for Clinical Supervision**

This authorization may be rescinded or amended at any time. In accordance with the law and the code of ethics, counselling and psychotherapy is committed to respecting the confidentiality of the client and the strict preservation of anonymity and privacy.

For billing and insurance purposes, and in compliance with the CRPO, I am supervised by registered psychologist **Dr. Augustine Meier, Ph.D., C. Psych, (Reg. No. #1651)**.

I, the undersigned, authorize Lorena Ibacache to consult/release information to her supervisor, for insurance purposes and/or professional development.

(Please initial one): Yes_____ No_____

3. **Agreement on Fees**

The agreed upon fee per session is: $ _____ (Please initial): _____

Client Consent to Treatment

I agree to these conditions and wish to begin therapy.

Name of Client: _____ Signature: _____

Name of Therapist: *LORENA IBACACHE* Signature: _____

Date: _____