Turning Point Psychological Services

1 Promenade Circle, Suite 313C
Thornhill, ON L4J 4P8
(647) 444-6030
www.turningpointpsychology.ca

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Sex:** _____

Occupation: _____

Email: _____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact Person:

Name: _____ Relationship to Patient: _____

Telephone: _____

Referred by: _____

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CONSENT FORM

Name/s of Patient/s: _____

This form is to document that I/we give permission and consent to Anna Prudovski, M.A., C.Psych., a certified member of the College of Psychologists of Ontario, to provide psychological consultation, assessment, and/or treatment to me/us and/or
my child_____
I understand that I/we have the right to withdraw consent for psychological services at any time.

I understand that Anna Prudovski, M.A., C.Psych., the Clinical Director of Turning Point Psychological Services, is responsible either directly or through a supervised service provider, Julia Zhreretiy, B.Sc, RP (Qualifying), for all aspects of the psychological services provided to me/us or my child. I further understand that the supervised provider, though not a registered member with the College of Psychologists of Ontario, has the required training to deliver psychological services under the supervision of a Clinical Psychologist. If I wish to speak with Anna Prudovski, M.A., C.Psych., I may do so by calling 647-444-6030. When necessary, it is possible to schedule a meeting with Anna Prudovski, M.A., C.Psych., at my request, or at the request of the supervisee.

I understand that psychotherapy entails both benefits and certain risks, and that there is no guarantee that psychotherapy will be successful. I understand that it is important that I mention promptly any concerns or questions I may have at any time during the process of therapy to my therapist.

CONFIDENTIALITY

Confidentiality is respected at all times and no information will be released to a third party without my informed consent, with the following exceptions:

- If a patient is considered to be an imminent threat to her or his physical safety or to the safety of others.
- If there is suspicion of child abuse or neglect, the appropriate child welfare authorities will be notified.
- If a patient has been sexually abused by another member of the same or a different regulated health profession.
- If a court orders the disclosure of records.

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PAYMENT FOR SERVICES & FEES

I agree to pay for all psychological consultation and counselling/ psychotherapy services provided to me/us or my child at the rate of $ 180 per hour. The usual hour is 50 minutes as set out by the Ontario Psychological Association (O.P.A.). I agree to pay *in full at the beginning or the end of each session*, unless another arrangement is agreed upon.

Fees may vary according to the time and nature of the service(s) involved (e.g. written report, letters or other form of written correspondence, as well as Court attendances, will be billed based on the hourly rate; telephone conversations in excess of 10 minutes will be billed at your regular appointment fee, in quarter hour increments; and consultation with other professionals will be billed at your regular appointment fee, in quarter hour increments) and you will be advised in advance if any changes are made to the fee. All fees charged follow the guidelines set by the O.P.A. for psychological consultation and counselling.

Generally, patients pay for their sessions at the beginning of each session. A surcharge of $25.00 will apply to all N.S.F. cheques. A late fee of 2% per month will be added if payment is not received after 60 days of the date of service. Outstanding accounts of more than 60 days will be eligible for submission for collection.

There is a 48-hour cancellation policy. If you are unable to attend your appointment, please notify me 48 hours in advance, **otherwise you will be charged the full amount of the session.**
Initials and signature: _____

Would you like feedback provided to your physician? Yes❑ No❑ Undecided❑

This consent form has been reviewed with me/us. I have had an opportunity to ask questions, and I/we understand its contents.

Date: _____

Printed Name: _____

Signature of Patient: _____

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CREDIT CARD AUTHORIZATION FORM

I:_____

hereby authorize this card to be used by Turning Point Psychological Services for the psychotherapy sessions, as well as for missed appointments and cancellations with less than 48 business hours' notice.

Credit Card Information:

Name as it appears on the Card:

_____

Type of Card: □ VISA □ MASTERCARD □ AMERICAN EXPRESS

Credit Card Number_____- _____- _____- _____ Expiration Date_____/_____

Credit Card Billing Address: Street: _____
CVV Number_____

City: _____Province: _____ Postal Code: _____

Telephone: _____

E-Mail: _____

Cardholder Signature: _____

Date: _____/_____/_____