



## **Couples Informed Consent Intake Form**

I understand that therapy often involves discussing difficult aspects of life and I may experience feelings like sadness, guilt, anger, frustration, loneliness, and helplessness in the course of our work.

It is also my understanding that the benefits of counselling and psychotherapy include but are not limited to: increased self awareness, improved interpersonal relationships, a virtualized sense of self, discovery of meaning and purpose in life, solutions to problems greater ability to express thoughts and emotions and reduction in feelings of distress.

I understand that there are potential risks and benefits with any form of psychotherapy and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases I may feel worse. I will discuss my ongoing experiences in therapy and ask about alternative courses of action when I wish, I understand this is my right.

I understand that my therapist as part of his ongoing professional development consults with a Supervisor and with Nadine Saxton, Somatic Psychotherapist, his partner in practice. Also, that some sessions may be recorded for the purpose of supervision but will be destroyed immediately following the supervision. If the session is to be recorded, additional consent will be sought.

I understand the consequences of not engaging in psychotherapy are varied and cannot be defined in a general way.

I understand that I have the following rights with respect to Psychotherapy.

- I understand that my therapist may use a wide variety of therapeutic techniques including Family Systems, Somatic, Humanistic, Emotionally Focused Therapy, Enneagram typology and Transpersonal methods, and will suggest exercises based in this varied methodology. My therapist will explain these to me as is reasonable in the process of our work together.
- I have the right to withhold or withdraw consent at any time to all or part of this while respecting the proper conduct of therapy, without affecting my right to future care or treatment.

## Confidentiality

The information disclosed by me during the course of my therapy is confidential. However, there are exceptions to confidentiality, including, reporting child, elder and any dependent adult abuse, expressed threats of violence towards a victim; legal subpoena.

- I understand I have the right to my file and copies of records on request, subject to reasonable notice.

## “No Secrets” Policy for Couple Therapy:

This written policy is intended to inform you, the participants in couple therapy, that when I agree to work with a couple, I consider that couple (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple, I will seek the authorization of both members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the couple).

During the course of my work with a couple, I may see one part of the couple for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session with the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination

I understand that I have the following responsibilities with respect to Psychotherapy:

- I recognize that therapy is a mutual process in which there is a shared responsibility for decision-making and action toward healing, growth, and realization of potential. My responsibility includes the recognition of my own agency and **capacity for choice** and the necessity that I be engaged in the creation, development and enactment of all therapeutic processes.
- I agree to be responsible for the fee of \$176.99 / hour plus HST (\$200.00 - unless other arrangements are made). I will be given reasonable notice before any anticipated change of fees. I agree to pay for services when delivered unless other arrangements are agreed upon.
- I understand there is a **24-hour cancellation policy**.

I agree to be responsible for payment for any scheduled session I do not attend if I have not given at least 24 hours' notice. I understand that this does not apply to emergency situations, in which case I will give as much notice as possible.

#### Email

I can communicate with my therapist via email but understand that confidentiality may be compromised due to the technology used.

If my therapist responds via email in depth, I will be charged for his time accordingly.

#### Other

I have a right to a receipt for services on request.

I will notify my therapist of my prescription medications and any changes in their usage.

I agree to share information regarding my mental and physical health as assessed by previous practitioners, including any disagreements I may have with their perspectives.

I understand that if my needs are beyond the scope of the therapist's expertise, I will accept a referral to another practitioner.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my therapist and, any questions have been answered to my satisfaction. I consent to pastoral counselling and psychotherapy treatment by Nadine Saxton

Signature\_\_\_\_\_

Signature\_\_\_\_\_

Date\_\_\_\_\_

Welcome to my practice.

I sincerely commit to working with you to the best of my ability so that your counselling and psychotherapy experience will be deeply rewarding.

*All information will be treated as confidential*

Registered Psychotherapy # 001972

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