ConsciousLiving

Infinite Possibilities

INFORMED CONSENT FORM

Conscious Living Wellness Services Inc. (CL) provides psychotherapy services at a rate of $240/60 min for all appointment types; payable by e-transfer only; **please send e-transfers to dr.kyla@csliving.ca on the day of your appointment.** This fee is partially reimbursable by most insurance plans and can be used as a tax deduction.

Confidentiality – Information you share is confidential and will not be released to anyone outside CL without your consent. **Exceptions** to this are if you are at imminent risk of harming yourself or someone else, if a child is in danger of abuse, or if my records are subpoenaed by a court of law. Furthermore, for administrative and accounting purposes, limited identifying information may be provided to administrative staff and external consultants. CL also has access to your identifying information for the purposes of obtaining client evaluation of services feedback. Failure to provide payment for services scheduled will result in your billing being forwarded to a collection agency after 6 months.

It is important to note that cell phone conversations pose a risk to confidentiality. The video calling methods that CL uses are encrypted to reduce the likelihood of breaches of privacy. However, with any method of communication, a breach of privacy and therefore confidentiality is possible. There are other potential disadvantages as well as advantages associated with video/phone therapy sessions. Please discuss any concerns with your psychologist.

Cancellation Policy – A**t least 48 hours cancellation notice using the online schedule is required.** This allows someone else to use your spot. Unless there is a serious emergency, if you do not provide at least 48 hours notice a **50%** late cancellation fee will apply. If at any time you fail to schedule further sessions, it will be assumed that you have chosen to discontinue therapy.

Number of Sessions – If you require longer term counseling than your insurance benefits provide or can no longer afford the fees outlined, you may be referred to an agency that provides lower cost services.

Fit Between You and Your Psychologist – It is essential to therapeutic success that you feel comfortable with your psychologist and her approach. If at any time you have any concerns, please feel free to discuss them and alterations to the counseling process or provisions for a referral will be made. To enhance our services, direct feedback is appreciated.

Purpose and Nature of Psychotherapy – Please discuss with your psychologist your goals in therapy as well as the therapeutic approach. Be aware that there are many alternative approaches that may be effective for you.

Risks/Benefits – There are potential risks and likely benefits to therapy. There are also risks of choosing not to engage in the therapeutic process. Please discuss these with your psychologist.

We encourage you to take an interactive role in the therapeutic process to achieve the most benefit. If at any time concerns or questions arise, please raise them. **Please call me Kyla!**

Your signature indicates that you have read, discussed any questions you have, and understand all of the above information and agree to treatment. You are free to withdraw consent at any time.

______________________________	______________________	________________
Name (print)	Signature	Date
______________________________	______________________	________________
Name (print)	Signature	Date

Conscious Living Wellness Services Inc.
Kyla Yaskowich, Ph.D. | Registered Psychologist e: dr.kyla@csliving.ca | c: 604.542.7130
#901 - 601 West Broadway, Vancouver . BC. V5Z 4C2

INFORMATION FORM

Date: ________________________

How did you hear about my services?____

Last Name: ____

First Name: ____

Birthdate: ___________________________________

Phone: _________________ cell: __________________________ (messages ok?) YES_____ NO _____

Home Address: ____________________

Email: ___________________________

Please email me (a few times/year) about upcoming Seminars YES_____ NO _____

Please email me occasionally to provide your Wellness Newsletters YES ____ NO _____

Hourly Rates: **$240.00/60 min In-Office or Video/Phone**
50% Late Cancellation Fee – if less than 48 hours notice is provided

I hereby accept services from Kyla Yaskowich, Ph.D., R.Psych. under the terms and conditions which have been reviewed with me on the Informed Consent Form on file. I accept personal responsibility for missed appointments and any billings not payable by third party coverage.

_______________________ Name (Print)

__________________________ Signature

_______________________ Date

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COVID FORM

INFORMED CONSENT FOR IN-PERSON PSYCHOLOGICAL SERVICES

This protocol is based on the requirements outlined by the BC Ministry of Health and WorkSafeBC for in person counselling in light of the ongoing risks associated with Covid-19.

Agreement to Meet for In-Office Appointments

We have agreed to meet in person for some or all future sessions. However, if there is a resurgence of the pandemic or if other health concerns arise, virtual therapy sessions may be required. By attending appointments at our office, you are assuming the risk of exposure to Covid-19.

Your Responsibility to Minimize Your Exposure

To obtain services in our office, you agree to take precautions to reduce the risk of transmission of Covid-19 for the health and safety of all. If for any reason it is not possible to adhere to the safeguards below, please change your appointment to a virtual one using the online scheduler or by texting me at 604-542-7130.

Your signature below indicates that you agree to the following safety protocol:

- I will only attend an in-office appointment if I am experiencing no signs illness.
- If I am experiencing even mild symptoms of illness I will change my appointment to a virtual appointment and the late cancellation fee will be waived.
- I will follow all provincial health guidelines to minimize exposure to Covid-19.
- If I have had any exposure to people infected with Covid, I will change my appointment to virtual.

Any changes to these precautions will be discussed as they arise.

My Commitment to Minimize Exposure

Conscious Living Wellness Services and myself have taken the necessary precautions to reduce the risk of spreading Covid-19 within the office. Please let me know if you have questions regarding these safety precautions.

Your signature below indicates that you understand and agree to the above stated terms and conditions.

______________________	______________________	______________________
Name (Print)	Signature	Date

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