Seymour
Psychological Services
Life Matters

1658 Bedford Highway,
Suite 2030, Bedford Place Mall
Bedford, NS B4A 2X9

Phone: 902-832-1918
Fax: 902-832-4369

CONTRACT FOR SERVICES

Name(s) of Clients(s):_____

Date of Birth(s):_____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Cell Phone: _____ **Alt Phone:** _____ **Email:** _____
(*Please circle the number(s) at which it is ok to leave a message.*)

I hereby acknowledge that I have been informed of and /or agree to the following stipulations regarding the services I am attaining from **Seymour Psychological Services Inc:**

1. The fee is **$200.00 for Individual**, C**ouples' and/or family Therapy --** based on the standard of **50 minutes** of counseling/assessment time and 10 minutes of administration/recording time. Assessment services, requested correspondence and/or reports will be provided at an additional fee which will be discussed and agreed upon before such services are provided.

2. I am responsible for ascertaining whether the services I am receiving are covered by my supplemental health insurance plan; I have been provided a NSBEP Registration Number and, where relevant, have been informed of the meaning of "Candidate Register" status.

3. **MISSED APPOINTMENTS, INSUFFICIENT CANCELLATION OR RESCHEDULING NOTICE:** As a courtesy to our clients on our waiting list and to your Psychologist, our policy concerning missed or rescheduled (without sufficient notice) appointments is adhered to without exception. In signing this consent form you are agreeing to the terms outlined below. If you require clarification of any point, please discuss with your Psychologist before signing **A booked appointment is time that has been reserved exclusively for you. This time remains your financial responsibility unless you release it for use by someone else by providing:**

   At least 24 hours' notice of cancellation or rescheduling. Monday appointments must be cancelled/rescheduled by 12 noon on the previous Friday. Appointments scheduled on the first day following a holiday must be cancelled/rescheduled by 12 noon on the last business day before the holiday. 48 hours' notice is required for appointment scheduled for 2 hours or longer.

   The cost for time missed or cancelled/rescheduled without sufficient notice rests with you. In the case of illness or inclement weather, a telephone session can be arranged for you.

   The fee for missed appointments is the same as for appointments attended. Fees for missed appointments must be paid in full to retain any further appointments in our schedule.

   ****Receipts for missed appointments will indicate "Missed Appointment" and may not be covered by insurers.***

4. LATE ARRIVALS AND EARLY DEPARTURES: ***Unfortunately, time lost because of the above cannot be made up. Please call our office if you are going to be late, and your Psychologist will wait for you to begin your session. Any late arrivals beyond 20 minutes without notice will be considered cancelled.***

Seymour
Psychological Services
Life Matters

1658 Bedford Highway,
Suite 2030, Bedford Place Mall
Bedford, NS B4A 2X9

Phone: 902-832-1918
Fax: 902-832-4369

Payment Authorization

I agree that fees will be charged to my credit card account for appointments missed or cancelled without sufficient notice, as described above, and hereby authorize any such charges. This authorization guarantees my future appointments will be reserved for me.*

_____ _____ _____
Credit Card # Exp Date CVC #

- **I understand that fees for appointments missed or cancelled without sufficient notice, as described above, will be paid immediately. I realize that without immediate payment, appointments already scheduled for me will be cancelled and that my account will be forwarded to a collections agent if it remains unpaid after 30 days.**

I have read, understand and agree to the terms noted above:

Signature_____Date_____

Signature_____Date_____

Seymour
Psychological Services
Life Matters

1658 Bedford Highway,
Suite 2030, Bedford Place Mall
Bedford, NS B4A 2X9

Phone: 902-832-1918
Fax: 902-832-4369

CONSENT FOR PSYCHOLOGICAL SERVICES

I (name)_____, and

I (name)_____

Hereby consent to participate in counseling or therapy with **Seymour Psychological Services Inc** and understand and agree to the following:

1. The goals and dynamics of contact with my therapist will be discussed and agreed upon during our initial session.

2. Participation in therapy carries some risks, including but not limited to, changes in mood and behaviour, which may also have an impact upon relationships and/or work and daily tasks.

3. Any confidential material may have to be disclosed if subpoenaed by a court, if a risk of harm to self or others is divulged during contact with the therapist, or if an ongoing risk of child or elder abuse is revealed during sessions. Confidentiality of identifying information may also be breached if necessary in order to secure payment for delinquent accounts through collection agents of the courts. No legal action will be taken on such accounts without prior notice to clients.

4. The NS Board of Examiners in Psychology (NSBEP) has the right to audit a psychologist's files if they perceive the need to protect the public.

5. My psychologist will seek my express written authorization to communicate with third parties, including my other health care professionals (i.e., family doctor). These health professionals may be entitled to share this information with other health professionals, not expressly authorized by me. In these cases, my psychologist has no control over such sharing of information and cannot be held responsible for the same.

6. To maintain a level of professional integrity, psychologists are required to consult with other psychologists on an ongoing basis. Every effort is made to ensure client confidentiality.

Signature_____ Date_____

Signature_____ Date_____

Physician's Name and Location:_____

Referred By (if different from above):_____

Please indicate whether you would like **Seymour Psychological Services Inc** to correspond with and provide relevant information/reports to your physician regarding the psychological services you receive:

YES/NO

Signature_____ Date_____

Signature_____ Date_____