

Chelsea Conron, M.A. (expected completion 2011)

Clinical Counselling & Psychotherapy

live . breathe . grow



Consent to Services Form

- Therapy is a relationship that works in part because of the clearly defined rights and responsibilities held by each person. There are also certain limitations to these rights that you should be aware of. This form is the beginning of an ongoing dialogue about these rights and responsibilities, and a therapeutic relationship that centers around your well being.
- I am in my final year of a M.A. in clinical counselling from Trinity Western University (expected completion 2011). To date I have completed over 600 hours of supervised clinical experience. My areas of special training and expertise including post traumatic stress disorder (PTSD), developmental and single incident trauma, emotional and relational concerns, depression, anxiety, self-esteem, addictions, sexuality, and life transitions. I am trained in Observed and Experiential Integration (OEI), which is a trauma processing “power therapy” that involves covering and uncovering of the eyes, and eye movements in order to help the individual reconnect with life in a fuller capacity. This therapy has been clinically and scientifically validated to treat everything from performance anxiety, to single incident traumas such as car accidents or rape, to childhood abuse. If you are interested in this therapy, or if I believe it may be helpful based on your presenting concern, we can discuss this in our initial sessions together. I am happy to answer any questions you may have about my credentials, previous experience, and therapeutic approach.
- You have the right to confidentiality. No information will be shared without your consent, within the legal and ethical guidelines. All written information is kept secure under a minimum of two locks. You have the right to request a copy of your file at anytime. You have the right to request that I correct any errors in your file. Any electronic communications that we may have will be password protected, but please note that such communications are not completely secure, as they are normally kept in the logs of the internet service provider. At times it may be beneficial for me to consult with other healthcare providers with whom you may be involved. In such cases your written consent for the release of information is required.
- There are a number of limitations to confidentiality, where I may need to share information without your consent. I will, however, do my best to discuss such instances with you and handle them with the utmost of care. These limitations are as follows:



- A. When there is risk of imminent danger to you or another person, I am ethically bound to take the necessary steps to prevent such danger.
- B. When there is reason to believe that a child or elder is being sexually, physically, or emotionally abused or is at risk of such abuse, I am legally required to take steps to protect the individual, and inform the proper authorities.
- C. When a valid court order is issued for treatment records, I am bound by law to comply with such requests.

🍃 In order to continue to improve my skills as a clinician, I frequently consult with other counselors with whom I am professionally affiliated. I also receive ongoing supervision from Richard Bradshaw, Ph.D., a registered clinical psychologist, in the form of case consultation. When consulting and receiving supervision, all identifying information is kept strictly confidential. I may occasionally make use of audio or video recordings in therapy in order to review and improve my services, or as a therapeutic tool with clients. Recordings are kept temporarily on a locked computer in a secure location. Once reviewed, they are deleted. You will never be recorded without your permission in the form of written consent. You have the right to request to view these recordings at any time, and I may even recommend this as a part of treatment.

🍃 My fee, unless otherwise agreed upon, is 110.00 per session, to be settled at the beginning of your appointment. Sessions are based on a 50 minute hour. Occasionally I recommend hour and a half sessions for individuals who are working on particularly intense issues, in order to allow enough time for stabilization. If we decide upon this at some point, the fee will be adjusted to 140.00 per session. You are responsible for showing up to your scheduled sessions on time. If you arrive late, we will still end at the previously arranged time. There is a 24 hour notification requirement for cancelled appointments. Missed appointments will result in being charged for the full cost of the session. The only exceptions are sudden, unexpected illness of you or a close relative, and weather conditions that would prohibit safe transportation.

🍃 You have the right to withdraw from services at any time. However, it is my sincere hope that if you are not satisfied with your treatment in any way, we may discuss this and allow for an opportunity to rectify any misunderstandings before you make the decision to end services. Please be aware that psychotherapy may involve emotional or mental distress depending on the content of our work together. Sometimes individuals report feeling worse before they notice improvements as they uncover and work through challenges. It is my goal to help you acquire skills and resources from which to draw upon as we work together towards your treatment goals.

In case of a crisis or emergency please call the Fraser Health Crisis Line: 604-951-8855 (local) 1-877-820-7444 (toll free), or 911. Dialing 211 will connect you with someone who can help you find a variety of local resources such as shelters, and support groups.

By signing below you indicate that you have read and understood the information in this form, and that you consent to therapy with Chelsea Conron at the Lifestyle Health Centre. You may ask questions regarding this consent form and/or your treatment at any time.

_____	_____	_____
Client Name (Please Print)	Signature	Date

_____	_____	_____
Parent/Guardian Name (Please Print)	Signature	Date

_____	_____	_____
Counsellor Name	Signature	Date

We periodically review our services with clients, and welcome your feedback. Please indicate below if you are interested in being contacted at some point about your experience with our agency. ___ Yes ___ No