Georgetown
Child, Adolescent and Adult Counselling Centre
Offering Social Work, Psychotherapy & Counselling-Therapy

Client's Name First:_____ Last Name:_____

Date of birth: _____ **Insurance Company** _____
(mm/dd/yyyy)

Address:_____

_____

HomePhone:_____ CellPhone:_____

Home Email:_____

Emergency Contact:_____ Relationship:_____

Phone Number:_____ Cell:_____

Nature of your visit please describe:

_____

_____

Medications:_____

_____

I hereby understand that Psychotherapists, Therapists, Social Workers, and or Support Staff on site at Georgetown Counselling Centre are not Doctors, Lawyers, or direct representatives of any WSIB, MVA, Health or Medical insurances and or drug companies. Any questions or discussions to any Therapists, Social Workers, and or Support Staff on advice in any of these areas and or discussions relaying information is not advice and should not be treated as such. You must not rely on the information as a replacement from speaking with a licensed Doctor, Lawyer, Pharmacist or Insurance professional.

I herby understand that Georgetown Counselling Centre will keep your information confidential with the following exceptions: 1. If you give Georgetown Counselling Centre permission to tell your personal information to others. 2. If there is a risk of you harming yourself or someone else (I will seek the appropriate help for you) 3.If we are legally obligated to do so (court ordered) 4. If you are in any present danger or in harms way of another individual. Parental/Guardian Consent signature for children under the age of 18 I have read the above and agree to the terms and agree for said child to receive treatment from Georgetown Counselling Centre.

I _____ Have read and understands what it means to not replace discussions with others as official advice from a Licensed professional I hereby also consent my information being held on file for up to 7 years and agree to receive counselling treatment from Georgetown Counselling Centre. _____ (initial)

Name _____ Signature_____

Date _____ Session Fee: _____
MM/DD/YY Based on 1Hour = 50 minutes

I understand that payment is due in full at the end of each session and a receipt will be given when payment is received. Any services covered by insurance will be paid in full in office and I understand I am responsible to submit my own required documents to my insurance provider. (services covered vary between various plans please check with your insurance provider)
Acceptable methods of payment are VISA,DEBIT,CASH, EMAIL MONEY TRANSFER

We understand that unanticipated events happen occasionally in everyone's life, but we still require contact if you are not attending your appointment.Please keep in mind that late cancellations or "no show" appointments leave therapists with empty appointment slots that other clients in need could have used.
In order to provide a professional service and to avoid disruption of our services from no-shows and short notice cancellations, and to ensure proper availability for all our clients, including you, we operate a **full-fee 48-hour notice cancellation policy.**