Pat Ferris Consulting
Connecting with Compassionate Expertise

Pat Ferris, MSW, RSW, M.Sc., Ph.D.

Date_____

Part I

Last Name:		First Name:			
Work Phone:		Home Phone:		Cell Phone:	
	msg Y / N		**msg Y / N**		**msg Y / N**
Gender: M ☐ F ☐		Birthdate: (d)		(m)	(y)
Emergency contact: Name:		Phone:			
Email Address:					
Street Address :					
City:		Province:		Postal Code:	

Part II

Family Doctor Referral (Name): Name_____
Clinic_____

May I let your Dr. know you have attended today? Y___ N___

Part III

Issue of concern (briefly describe): _____

_____

Cancellation Policy

24 hour notification by email (ferrispa@telus.net) is required to cancel an appointment. Late cancellations will be billed at the full amount of a session.

Re: Informed Consent for Provision of Psychotherapy Services

All information discussed with your counsellor will be treated as confidential. As follows, there are some circumstances under which this information could be disclosed:

1. If you have signed a Release of Information to a specific person or persons with regard to specific information.
2. If in the professional opinion of your counsellor there is potential for physical risk to you or others.
3. If there is a legal obligation to report (as in cases of child abuse).
4. If the counsellor is legally required by a court of law to testify or submit a report or release records.
5. For clients attending through a company Employee Assistance Program: Please be advised that we supply your company with non-identifying statistical information.

My signing this means that I have read and understand the above information.
I also understand my responsibility regarding cancellation policy.

Date: _____ Signature: _____