HÉBERT & ASSOC.

* Please print this sheet, fill out and bring to your first appointment.

CLIENT

Name:

Address:

City: Postal Code:

Tel. (H):

(W):

(C):

Email:

D.O.B.:

File #:

FAMILY DOCTOR

Name:

Address:

City: Postal Code:

Tel.

Fax:

THIRD PARTY

Name:

Contact person.:

Address:

City: Postal Code:

Tel.:

Fax:

SPECIALIST (if applicable)

Name:

Address:

City: Postal Code:

Tel.

Fax:

EMERGENCY CONTACT

Name:

Tel. (H):

(W):

(C):

Relation:

LIST ALL CURRENT MEDICATION

	Name	Dosage
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

OTHER INFORMATION

Referred by:

Ref. Reason:

For office use only:

Date of Assessment:

Service provisions:

Consent form:

Questionnaires:

Late/canc. Fees:

Other information:

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HÉBERT & ASSOCiates
iié(e)s
Psychological Services / Services psychologiques
203 MacLaren St., Ottawa, ON K2P 0L4 | Tel. 613.565.9090 | Fax 613.565.0404
www.Hebert.ca

Dr. Francine Roussy Layton, C.Psych., Ext. 222
Dr. Catherine Sabourin, C.Psych., Ext. 228
Dr. Carole Lamarche, C.Psych., Ext. 224
Dr. Lisa Carswell, C.Psych., Ext. 231

Dr. Gilles Hébert, C.Psych., Ext. 223
Gilles Hébert | Psychology Professional Corporation | Société Professionelle de Psychologie
Dr. Lorraine Y. Overduin, C.Psych., Ext. 226
Lorraine Overduin Psychology Professional Corporation

Dr. Alison Welsted C.Psych., Ext. 225
Dr. Daniella Sandre, C.Psych., Ext. 229
Dr. Adam Heenan, C.Psych., Ext. 232
Dr. John Kowal, C.Psych., Ext. 227

CONSENT TO DISCLOSE AND/OR RECEIVE INFORMATION

I, Mr./ Ms. _____ hereby authorize _____ to:

____ A. Send copies or provide information verbally concerning my assessment, treatment plan, progress notes, discharge summary and follow-up reports to the individual(s) listed below.

____ B. Communicate with the following individuals to receive information concerning my psychological status, my treatment, my medical status, or other information relevant to my psychological assessment and/or treatment.

_____ Caseworker

_____ Family physician

_____ Rehabilitation consultant

_____ Specialist

_____ Insurance company

_____ Other (please specify)

I have read and understand this information and provide my consent by signing and initializing this form. I also understand that this consent is valid for 12 months but may be revoked at any time. If I revoke my consent to communicate with a third party payer, I understand that psychological services will likely not continue.

_____ Client's signature

_____ Date

_____ Witness

_____ Date

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PRINCIPLES OF SERVICE PROVISION

Dear client, the following is intended to provide you with information concerning the manner in which I operate my practice. If you have any questions, please do not hesitate to bring these to my attention.

ADMINISTRATION OF PRACTICE

I am registered in the Province of Ontario, and I am therefore accountable to the organisation that is responsible for the licensing of Psychologists in Ontario. The name and address of this organisation is:

College of Psychologists of Ontario
110 Eglinton Ave. West, Suite 500
Toronto, Ontario M4R 1A3
Tel. 800-489-8388

FEES

The services you receive from me are **not** covered by the provincial Health Insurance Plan (OHIP or Assurance maladie du Québec). Some extended Health Care Plans offer at least partial coverage of services provided by Psychologists. If such coverage is available to you, please provide me with the appropriate forms and I will be happy to co-operate. **If you have been referred by an insurance company, government agency or WSIB, the fees will be covered by the referral source.**

Consultations are 50 minutes in duration. Fees for all clinical services are billed at an hourly rate and I ask that this fee be paid on the same day of the provision of service. Because I am registered provider of psychological services, the fees you pay for direct clinical services (counselling, psychotherapy, etc.) constitute a tax deductible medical expense. The bills you receive, in addition to specifying charges due, also list any payments you have made and can be attached to your income tax form to enable you to claim the medical expenses deduction. In cases where an extended health care plan provides partial coverage of fees, the appropriate claim would be the portion of the fee not covered by your health care plan.

CANCELLED OR MISSED APPOINTMENTS

Since the number of requests for service I receive frequently exceeds my capacity to provide such, I am often forced to construct a waiting list. In addition to undermining the continuity and momentum of the service you receive from me, cancelled or missed appointments increase the length of the waiting period for those that I am unable to see immediately. Consequently, a notice of at least 48 hours is requested for any cancellation. There is no fee for a cancelled appointment if you provide 48 hours notice (2 business days). Please let me know of any special circumstances, as the entire fee for the consultation may be charged to you or the third party that pays for your psychological services if you have cancelled your appointment less than two days before.

CONSENT

I typically work in conjunction with the family physician. In order for me to communicate with others, your written permission is required. You may revoke this permission at any time. Please read the consent form provided to you in this package and sign it if you feel comfortable doing so. If for any reason you are not comfortable with this, please wait until we have met and discussed your concerns.

WSIB (CSST) AND AUTOMOBILE INSURANCE

In cases where fees for treatment are paid **directly** by an organization such as WSIB (CSST) or an automobile insurance company, some issues discussed with me may be shared verbally and\or in writing with the rehabilitation consultant, the insurance company, WSIB (CSST) and your family doctor. In order for me to communicate with others, your written permission is required. You may revoke this permission at any time. Please read the consent form provided to you in this package and sign it if you feel comfortable doing so. If for any reason you are not comfortable with this, please wait until we have met and discussed your concerns.

QUESTIONNAIRES

You may be asked to answer one or more questionnaires. The purpose of these is to help in your assessment and to provide additional information that will help in your treatment. You are not obligated to answer these questionnaires.

LIMITS OF CONFIDENTIALITY

The matters you discuss with me are kept completely confidential, unless you provide consent for me to discuss or share the information with others. There are certain situations in which confidentiality cannot be maintained:

1. If I believe you are at serious risk of harming yourself or someone else.
2. If I receive information about child abuse (physical, sexual, emotional/neglect), and there is any degree of previous abuse, or current risk to a child, the law requires that I report this to the Children's Aid Society.
3. If ordered to do so by the court, I must surrender the information they request.
4. If I receive information about inappropriate sexual conduct of a regulated health professional, I must alert the respective college of that health professional.
5. If I receive information that leads me to believe that a vulnerable adult is at risk of abuse or neglect in a Long-Term Care Facility, I am obligated to alert the proper agencies and authorities.
6. If my College, The College of Psychologists, requests access to, or a copy of your file, I am obligated to comply with their request.
7. If I receive an "Urgent Demand" from the police, under the Missing Persons Act 2018, I am obligated to speak with, or provide copies of requested records to the police.

Thank you for your attention in this matter. Please feel free to ask any questions you may have about the information you have just read.

By signing below, I attest that I have read and understand the information written on both pages of this document, and that a copy has been provided to me for my personal records.

_____ _____

Client's signature Date

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