

# *Conscious Living Wellness Services Inc.*

406 - 1168 Hamilton Street, Vancouver, BC, V6B 2S2

(604) 542-7130

Kyla Yaskowich, PhD, Registered Psychologist #2066

## COUPLES INFORMATION FORM

Date: \_\_\_\_\_

How did you hear about my services? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: c) \_\_\_\_\_ messages ok? \_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Email:** \_\_\_\_\_

Please email me (a few times/year) about upcoming Workshops/Seminars YES \_\_\_\_ NO \_\_\_\_

Please email me occasionally to provide your Wellness Newsletters YES \_\_\_\_ NO \_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: c) \_\_\_\_\_ messages ok? \_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Email:** \_\_\_\_\_

Please email me (a few times/year) about upcoming Seminars YES \_\_\_\_ NO \_\_\_\_

Please email me occasionally to provide your Wellness Newsletters YES \_\_\_\_ NO \_\_\_\_

**Hourly Rate: \$260.00/60 min In Office (\$200.00/60 min Video/Phone)**

**50% Late Cancellation Fee for less than 48 hours notice to cancel**

I hereby accept services from Kyla Yaskowich, Ph.D., R.Psych. under the terms and conditions which have been reviewed with me on the Informed Consent Form on file. I accept personal responsibility for missed appointments and any billings not payable by third party coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date