



Kyla Yaskowich, PhD
Registered Psychologist

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COUPLES INFORMED CONSENT

Our services are provided to you at a rate of \$260/60 min in office (\$220/60 min Video/Phone), payable on the day of your appointment. Registered psychologists' fees are partially reimbursable by most health insurance plans. Please discuss any questions you have regarding the following information with your psychologist.

- 1. **Confidentiality** – Information you share is confidential and will not be released to anyone outside CLWSI without your consent. **Exceptions:** if you are at imminent risk of harming yourself or someone else, if a child is in danger of abuse, or if my records are subpoenaed by a court of law. For administrative and accounting purposes, your identifying information may be provided to administrative staff and external consultants. CLWSI also has access to your identifying information for the purposes of obtaining client evaluation of services feedback. Unpaid accounts will be forwarded to a collection agency after 6 months.

Cell phone conversations pose a potential risk to confidentiality. The video calling methods that CLWSI uses are encrypted to reduce the likelihood of breaches of privacy. However, a breach of privacy and therefore confidentiality is possible. There are other potential advantages and disadvantages associated with video/phone therapy sessions. Please discuss any concerns with your psychologist.

- 2. **Cancellation Policy** – Unless there is a **serious emergency**, a **50% late cancellation fee** will be charged if you do not provide at least **48 hours cancellation notice by phone or via the online schedule**. If at any time you fail to schedule further sessions, we will assume that you wish to discontinue therapy.
- 3. **Number of Sessions** - If you require longer term counseling than your insurance benefits provide or can no longer afford the fees outlined, your psychologist may refer you to a lower cost outside agency.
- 4. **Fit Between You and Your Psychologist** – It is essential to therapeutic success that you feel comfortable with your psychologist and his/her approach. If at any time you have concerns, please feel free to discuss them with your psychologist and alterations to the counseling process or provisions for a referral will be made. To enhance our services your direct feedback is appreciated.
- 5. **Purpose and Nature of Psychotherapy** - Please discuss with your psychologist your goals in therapy as well as his/her therapeutic approach. There are many alternative approaches that may be effective for you.
- 6. **Risks/Benefits** – There are potential risks and likely benefits to therapy. There are also risks of choosing not to embark on this process. Please discuss with your psychologist.

We encourage you to take an interactive role in the therapeutic process to achieve the most benefit. If at any time concerns or questions arise, please raise them. Furthermore, **please call me Kyla!**

Your signature indicates that you have read, discussed any questions with your psychologist, understand all of the above information, and agree to treatment. You are free to withdraw consent at any time.

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Name (print)	Signature	Date
Kyla Yaskowich _____	_____	_____
Witness	Signature	Date