DR. SHERRI BRUCE REGISTERED PSYCHOLOGIST#1458 INC.
#39-1400 Cowichan Bay Road
Cobble Hill, BC V0R 1L3

Teen Treatment Agreement (parent pays)

Name of Client: ____

Address of client: ____

____.

The Nature of the Treatment: Therapy

Benefits of Therapy

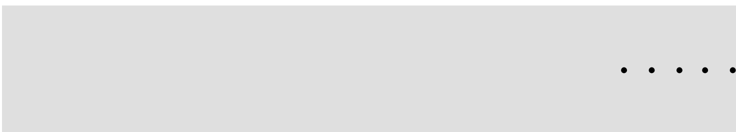
Therapy can help a person to gain new understanding about his or her problems and learn new ways of coping with and solving problems, such as anxiety, anger, depression, parenting or relationship concerns. Therapy can help a person to develop new skills and to change behaviour patterns. Therapy can contribute to an improved ability to cope with stress and difficult situations and can increase understanding of self and others.

Risks of Therapy

I acknowledge that, Dr. Sherri Bruce has advised me that while there are potential benefits to therapy, there is no guarantee of success and that there are potential risks. I have been advised that during counselling emotions and memories **may** be stimulated which can evoke strong feelings and that changes in awareness may alter my self-perceptions and ways of relating to others. I have been advised that the process of personal change can be varied and individual.

I understand that by using **Eye Movement Desensitization and Reprocessing** some clients **may** experience reactions during a treatment session that neither the psychologist nor the client may anticipate, including emotional or physical sensations.

I also understand that after sessions, the processing continues and other dreams, memories and feelings **may** emerge. I further understand that distressing and unresolved memories **may** emerge.



I, _______________________, understand that it is important that I mention promptly any concerns or questions to Dr. Sherri Bruce that I may have at any time during the process of therapy.

Sessions

The frequency of sessions and length of treatment will be guided by the needs and input from the client. Many issues and/or goals can be addressed through short term counselling while other issues and/or goals may need longer therapy. A session usually lasts one hour –sometimes longer. During a session, the session will focus on specific issues and directly work on at getting solutions using one or using all three theoretical approaches – Solution Focused, Cognitive Behavioural or Eye Movement Desensitization and Reprocessing.

I understand that **Solution Focused** therapy is an approach to psychotherapy based on solution-building rather than problem-solving. It explores current resources and future hopes rather than present problems and past causes and typically involves only three to five sessions.

I understand that **Cognitive Behavioural** therapy can be effective to deal with emotional and behavioural problems. The word "cognitive" means "to know" or "to think". Therefore, cognitive therapy is exploring your thoughts to understand how you feel and to explain what you do. Cognitive therapy explores the underlying thoughts, beliefs, and values that influence your perceptions that influence your feelings and behaviour.

I understand that **Eye Movement Desensitization and Reprocessing (EMDR)** facilitates the accessing and processing of traumatic events. EMDR can help clients process emotions, reformulate negative beliefs and reduce physiological arousal by targeting thinking and reprocessing the thoughts to more adaptive responses.

You may be asked to complete some tasks between sessions.

Consent to Treatment

In knowledge and appreciation of the benefits and risks as made known to me by Dr. Sherri Bruce, and as reflected in this form, I, _________________, hereby give my consent to **participate in therapy** for the purpose of addressing ____.

I further acknowledge that Dr. Sherri Bruce must obtain my informed consent before changing or altering the nature of the treatment or psychological services provided to me _____ (Client's initials).

Confidentiality and Limits of Confidentiality

Your sessions are entirely confidential according to the code of ethics of the College of Psychologists of British Columbia. The only legal/ethical exceptions to confidentiality are as follows:

- When a minor is at risk of abuse or neglect and is unable to seek support and assistance.
- When clients are at risk of imminent serious harm to themselves or others.
- When you disclose that you have a condition which makes it dangerous to drive and continues to drive after being warned of the danger.
- When you disclose you have an unreported communicable disease
- If the court orders the disclosure of client records.
- When there is a request from the College of Psychologists in the course of an investigation or a registration matter,
- If another licensed health care professional might be a danger to the public if he or she continues to practice (e.g., engaged in sexual conduct).
- When a client discloses that there has been cumulative stress, harassment or bullying due to their workplace.

I have been advised by Dr. Sherri Bruce that all communications and all records relating to the provision of psychological services to me are confidential and may not be disclosed without my written consent ____ (client's initials).

I have also been advised by Dr. Sherri Bruce that the law places certain limits on the confidential nature of the psychological services provided to me_____ (client's initial).

Fees

I, ___________________, agree to have my bills paid by my parents, ___________, and _________________ for all psychological services provided to me. I understand that the first session is for 1.5 hours at a cost of $300.00 and all subsequent session will be at the rate of $200.00 per hour. I agree to have my parent pay in full for each session at the beginning of each session unless otherwise agreed upon. These fees can be paid by cash, and debit, MasterCard or Visa.

In some rare cases, if we have reached the end of our session and it appears that you may need to resolve feelings of disturbance or distress, you may be asked if you would like to continue. You will then be charged and additional pro-rated fee for this time, which is payable at the end of the session.

All requests for copies of receipts, forms, report, and/or letters will be at a charge (refer to "*Fees for Forms*" sheet).

Cancelled appointments

I agree that if I cannot make a scheduled appointment that I must provide Dr. Sherri Bruce with at least 24 hours notice. I understand that I can contact the office by email drsherribruce@gmail.com or by telephone number, **250-743-7811** at anytime, 24 hours a day, to make, change or cancel an appointment. If I fail to do so, I acknowledge and agree that I will be charged, and agree to pay $200.00 for the missed or cancelled appointment. I agree that Dr. Sherri Bruce may use the credit card number on file to pay for that appointment _______, _______ & ______ (Client's and Parent/Guardian Initials).

Credit Card Number and Type: ____
Name of Credit Card: ____
Expiry Date: ____
Security Code on back of card: ____
Signed: ____

I, __________________, acknowledge that I have had the opportunity to carefully read this document to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document, that it records my consent to participate in the counselling process with DR SHERRI BRUCE REGISTERED PSYCHOLOGIST#1458 INC., according to the terms outlined above.

Client's Signature: ____________________________ Date: ______________

Parent/Guardian Signature: _____________________ Date: ______________

Parent/Guardian Signature: _____________________ Date: ________________

Provider: ____________________________________ Date: ______________

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Please note: Fees paid for psychological services are eligible for inclusion in your medical expense deduction on your income tax. Your extended health benefit plan may provide you reimbursement for fees paid for psychological services. You will be given a receipt for each payment which you should retain for income tax or other claim purposes.

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