



# GUIDANCE PROFESSIONAL SERVICES INC.



**“Helping You NAVIGATE Through Life”**

Creekside Professional Centre

#208, 4320-50<sup>th</sup> Avenue Red Deer, Alberta T4N 3Z6

Cell: 403-302-0031 Email: gpsinc@telus.net

## **INFORMED CONSENT-CHILDREN AND ADOLESCENTS**

*The purpose of this form is to share some important principles, which guide my counselling process so that your decision to place your child or adolescent into counselling with me can be based on accurate, informed expectations. Please read this carefully, or have it read for you, and feel free to ask any questions about what you have read or to have the information explained further. Informed consent is the parent's and/or child's or adolescence complete and active participation in decisions that affect them and the freedom of choice based on the information shared. It is a continuous process throughout the counselling relationship. **The parent and/or child adolescent have the right to refuse and/or withdraw from counselling at any time.***

## **PROFESSIONAL DISCLOSURE STATEMENT**

### **Qualifications:**

I have a Bachelor of Business Administration Degree, a Bachelor of Education Degree, and a Master of Arts in Counselling Psychology. I am a full member of the Canadian Professional Counsellors Association with the designations, **Master Practitioner in Clinical Counselling (MPCC) and Registered Professional Counsellor (RPC)**. In addition, I am a voluntary member with the Canadian College of Professional Counsellors and Psychotherapists with the designation, **Canadian College of Professional Counsellors and Psychotherapists Registrant (CCPCPR)**. As well, I am a **Clinical Traumatologist (TITC-CT)** with the Traumatology Institute. Ongoing professional development includes journalistic and textbook readings and research, online and face-to-face workshops, consultation with colleagues and supervisors, and active participation in personal growth and awareness.

### **Nature of Counselling:**

Counselling for me is a combination of therapies such as psychodynamic, attachment, cognitive-behavioural, and trauma-informed therapies, specifically Brainspotting as a body-brain modality for treatment, to provide clients with well-rounded therapeutic services. You are an individual and therefore unique, so therapy must meet these distinctive needs. Techniques may include active listening, self-awareness exercises, homework, psychoeducational discussions and readings, and record-keeping. I hold an unconditional positive regard of you and take a non-judgmental position, communicated via empathetic understanding. I consider your perspective and needs as the foundation for therapy. I believe you have the capacity and resilience to resolve your own problems and make your own decisions. However, from time to time, all of us need assistance, support, and direction so I will work with you to establish goals for your therapy. I believe the therapeutic relationship can significantly affect therapeutic outcomes.

### **Counselling Services:**

Counselling varies, depending on the personalities of the counsellor and client, and the particular problems presented in each session. Counselling calls for an active effort on your child's/adolescent's part. In order to achieve therapeutic success, they have to work on their problem as discussed; in each session, and at home. Counselling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of our lives, they may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. However, counselling has also been shown to have benefits for people who do the work. Therapy can lead to better relationships, new ways to cope with or solve problems, development of new skills, significant reductions in feelings of distress, changes in unwanted behaviours, and improvement in self-esteem and awareness. But there are no guarantees of what your children/adolescents will experience. Counselling is a process of self-awareness. I normally conduct an evaluation that lasts between 1-2 sessions. By the end of the evaluation, I will be able to offer your child/adolescent some ideas of what our work will include, along with a treatment plan if you decide to continue their therapy. It is important for you to evaluate this information with your children/adolescent. Once therapy has begun, I will schedule one **50-minute session** per week (or more or less depending on their counselling needs and availability) at a time we can agree on. If you have any questions about my procedures, techniques, or treatment plan, we can discuss them whenever they arise.



# GUIDANCE PROFESSIONAL SERVICES INC.



“Helping You NAVIGATE Through Life”

Creekside Professional Centre

#208, 4320-50<sup>th</sup> Avenue Red Deer, Alberta T4N 3Z6

Cell: 403-302-0031 Email: gpsinc@telus.net

## Confidentiality:

One of your most important rights as a client seeking counselling is confidentiality. Information revealed by you during counselling sessions will be kept strictly confidential and will not be revealed to any other person or agency without your written permission, **except** under the following circumstances:

**Duty to Warn:** If an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counsellor's duty to warn the appropriate individuals or agencies of such intentions. Also, any actual or suspected acts of child, elder, or disabled person abuse will need to be reported to the appropriate individuals or agencies by the counsellor.

**Court Order:** When lawyers believe that a client's counsellor may have valuable information for their case, they will subpoena her/his notes, records, and in some instances, even the counsellor themselves. In general, once a subpoena is served to a counsellor, it must be obeyed or the counsellor may be charged with contempt.

**Consultation:** Information about you may be discussed in confidence with other counselling professionals and/or supervisors for the purpose of consultation and providing you with the best possible service.

## Children, Adolescents, and Confidentiality

Counsellors who work with children and adolescents have the difficult task of protecting the minor's right to privacy while at the same time respecting the parent's or guardian's right to information.

Therapy is most effective when a trusting relationship exists between the counsellor and the child/adolescent. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will **not** share with you what your child has disclosed to me without your child's consent. At the end of your child's treatment, we will review the sessions in general, including what issues were discussed, what progress was made to date, and what areas are likely to require further interventions in the future.

## Record Keeping:

The laws and standards of my profession require that I keep client treatment records. I keep brief records, noting mainly that you have participated voluntarily in counselling, what interventions happened in session, and the topics we discussed. If you wish, you may receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by untrained readers. If you do want to see your records, I will ask that you review them with me at our next scheduled session so we can discuss the contents. You have the right to request that I correct any perceived errors in your file. I maintain your records in a secure location that only I can access.

## Fee Schedule:

The hourly fee for counselling sessions is **\$125.00 per hour** for individual/couples/families. This fee is to be paid **before** the session on the same day. Sessions longer than the regular hour will be billed accordingly.

## Client's Rights:

You have the right to ask questions about anything that happens in therapy with your children/adolescent. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. You can feel free to ask me to try something different, as well as refusing any counselling techniques. You are free to remove your child/adolescent from therapy at any point – though I recommend you participate in a termination session.

## Missed or Cancelled Sessions:

It is your responsibility to inform me **no later than 24 hours prior to your session** if you have to reschedule. If you do not attend a scheduled session and/or do not cancel your session with sufficient notice, **you will be billed the full fee for the cancelled/missed session.** Missed or cancelled sessions have the potential to be problematic and to place undue stress



# GUIDANCE PROFESSIONAL SERVICES INC.



**“Helping You NAVIGATE Through Life”**

Creekside Professional Centre

#208, 4320-50<sup>th</sup> Avenue Red Deer, Alberta T4N 3Z6

Cell: 403-302-0031 Email: gpsinc@telus.net

on the therapeutic relationship. To protect that relationship, my policy concerning missed or cancelled sessions is adhered to without exception. All missed or cancelled sessions with less than 24-hours' notice and **regardless of the reason, whether it be illness, emergency or inclement weather** will be billed the full fee.

A scheduled session is time reserved for your exclusive use. It remains your financial responsibility unless you release it for use by someone else by providing at least 24-hours' notice of cancellation, which allows me to offer the time to another client. Occasionally, a client thinks an exception should be made; but a scheduled session is time purchased and reserved for you. It is the same as you purchasing and reserving a ticket for an event, which would have to be paid for even if you could not attend, for whatever reason.

### **Emergencies:**

If you have an emergency, please contact your physician, local hospital, Crisis line **1-800-SUICIDE (784-2433)**, or **911**.

### **Obtaining Parental Consent**

*(please check one)*

- Parent has sole custody and sole guardianship and can only give consent.
- One parent has sole custody who can give consent and the other parent has sole guardianship.
- Parents share joint custody and one parent has sole guardianship. Either can give consent however consent from both parents is preferred.
- One parent has sole custody but both parents share joint guardianship. Custodial parent has final consent.
- Parents share joint custody and joint guardianship. Either custodial parent can give consent however consent from both parents is preferred.

Parent Contact Information:

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Acknowledgment and Consent:** Upon signing below, you are indicating that you have read, or had read for you, the above information, and you understand the contents of this form. You are indicating that any questions you had about this consent form have been answered to your satisfaction, and you were provided a copy. You agree to accept the counselling services as offered.

### **Consent for Treatment of Minors:**

I/we consent that my son/daughter/child under the age of 18, *(enter name of child)* \_\_\_\_\_ may be treated as a client by Stephen Roberts, Therapist.

**Parents: Do not leave the office while your minor child is with his/her therapist.** Your presence is necessary during your child's visit. In addition, it may be necessary for me to speak with you at some point during your child's session.

\_\_\_\_\_  
Parent or Guardian's name (please print)

\_\_\_\_\_  
Therapist Name (please print)

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Stephen Roberts, MA RPC MPCC CCPCPR TITC-CT

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date