BIRD & ASSOCIATES
PSYCHOLOGICAL SERVICES INC.

Child/Adolescent Intake & Consent Form

At our office, it's important for our clients to be aware of our policies and procedures before consenting for assessment or treatment. It's important to note that all participation at the clinic is voluntary. Clients can withdraw from services at any time during treatment. Please take some time to thoroughly read over our policies and please ask your clinician if you have any questions prior to signing the agreement.

Date: _____

Child/Adolescent's Name: _____

Parent/Legal Guardian: _____

Parent/Legal Guardian: _____

If separated, please describe the current custody/access agreement: _____

Date of Birth: _____ Age: _____

NS Health Card #: _____ Expiry: _____

Address: _____

City: _____ Postal Code: _____

Phone # (Home): _____ Alternate #: _____

Cell #: _____ Work #: _____

Emergency Contact Name & Number: _____

Can a personal voicemail be left on your phone(s)? Yes ◯ No ◯ If yes, which number? _____

Email Address: _____

Please indicate below if you would like to receive appointment reminders, and if so, by which method:

Email ☐ Phone ☐ Any Method ☐ I prefer not to be contacted for reminders ☐

BIRD & ASSOCIATES
PSYCHOLOGICAL SERVICES INC.

Would you like relevant health and wellness information emailed to you periodically? Yes ☐ No ☐

Please let us know how you heard about our clinic?: _____

If referred, would you like our office to let this person know you attended our practice? Yes ☐ No ☐

Confidentiality:

Limits of Confidentiality:

Your identifying information along with any information that is accumulated through assessment and or treatment is confidential. There are, however, legal limits to confidentiality. Please review the following:

1. **If your child/adolescent is deemed to be a high risk of hurting themselves or someone else, confidentiality must be broken in order to protect your child/adolescent or others.**
2. **If children/adolescents are in your possession, and it's thought that they are currently being physically, emotionally or sexually abused, then confidentiality will be broken in order to protect your child/adolescent.**
3. **If in the case that a Judge orders information from your child/adolescent's file, confidentiality must be broken.**
4. **In the case that you fail to pay any outstanding payment agreement in a timely manner, your account will be turned over to a collections agency and you will be responsible for payment of services and any amounts incurred by the collections agency.**

Confidentiality for Children/Adolescents: In order to establish trust amongst children and adolescents, it's important that the information that is obtained in sessions is confidential. Often children/adolescents disclose information to clinicians that they don't want their parents to know. If the information is not detrimental to the child's health or safety and it's asked to be kept confidential, that will be respected. If however the child/adolescent discloses information that is detrimental to their health and safety, the child/adolescent will be informed that the information must be disclosed to their parents.

BIRD & ASSOCIATES
PSYCHOLOGICAL SERVICES INC.

Collaboration:

A multi-disciplinary team of professionals working collaboratively can provide you with a holistic approach to your health. Your clinician may ask if you would consent to have them correspond with additional members of your child's school and/or health team. Please be aware that this service is on a voluntary basis and you have the right to choose whom your clinician does or doesn't correspond with.

In order to take a holistic approach to your health, it's often helpful to correspond with your Family Physician. Please indicate below who your family physician is and whether or not you consent to allowing me to correspond with them regarding your health. Please keep in mind that consent to correspond is voluntary and is not a requirement for access to service.

Family Physician :_____

◯ ***Yes***, I consent to allow you to correspond with my Family Physician regarding my treatment at your facility.
◯ ***No***, I do not wish for you to correspond with my Family Physician regarding my treatment at your facility.

A Psychologist **(Candidate Register)** is a Psychologist who has fulfilled their degree requirements, graduated but hasn't yet fulfilled the requirement created by the Nova Scotia Board of Examiners in Psychology to become fully registered. In order to be on the Candidate Registry, a Psychologist must meet monthly with their supervisor to review current research, ethical guidelines, procedures to ensure best practice and have the opportunity to have their work reviewed and critiqued.

Payment and Cancellation Policy:

Bird & Associates Psychological Services is a private practice and is not funded by MSI. We are happy to provide some of our clients with direct billing; however, it's important to check your insurance coverage to determine if your policy covers psychological services. It's also very important for you to track the amount remaining on your coverage, as you will be responsible to pay any outstanding balance(s) that your insurance does not cover.

The fees at Bird & Associates Psychological Services are $190 an hour for Psychologist, $200 an hour for family therapy. If an assessment is warranted, your clinician will provide you with a quote at the end of the first appointment.

BIRD & ASSOCIATES
PSYCHOLOGICAL SERVICES INC.

Please note that our clinicians have a waitlist. **In order to cancel an appointment without incurring a cancellation fee, we do require 24 hours' notice**. If you have an appointment scheduled for the following Monday and you're planning on cancelling, in order to avoid a cancellation fee, we require notice by 12:00 noon that previous Friday. If an appointment is missed without sufficient notice given, a cancellation fee of $125.00 will be invoiced to you.

In the case that you fail to pay any outstanding payment agreement in a timely manner, your account will be turned over to a collection's agency and you will be responsible for payment of services and any amounts incurred by the collections agency. At times parents who share custody of their children share costs associated with the treatment. It's important to note that it's not Bird & Associates responsibility to obtain funds from the other parent whose name is not on this signature.

***I, _____, have read the above agreement and I've had the opportunity to ask any questions related to consent for assessment and/or treatment. I am aware that access to psychological services is voluntary and at any time if deemed necessary I can withdraw consent to services.**

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name	Signature	Date