WELCOME to Dr. Beth Hedva & Associates

Before your first session, it is important that you have a general idea of some of the guidelines by which my counselling practice operates. I encourage you to discuss any of this information to ensure that your particular needs are met.

FEES and PAYMENT

The fee is $250.00 per 50 minutes and $375 for an extended 75 minute session. Emergency phone sessions are billed at $60/10 minutes. Payment is received at each appointment. I accept E-transfers, MasterCard, VISA and cheques or cash.

Third party payments are reimbursed directly to you; and you will be expected to pay for services at the end of each session. Depending on your insurance provider, coverage may vary. A receipt is provided for each session and it is the client's responsibility to submit it to the insurance for possible reimbursement.

CANCELLATION

There is no **charge for changed or cancelled appointments if 48 hours notice** is given.

Your courtesy in this regard is greatly appreciated. Should cancellation be considered because weather or other current circumstances prevent the client from travelling to the office, I will be pleased to conduct a session by SKYPE or by phone during the scheduled appointment time. **Full fees are charged on missed appointments or cancellations under 48 hrs notice.**

Likewise, if I cancel in less than 48 hours, you will be offered a complementary session to compensate you for the inconvenience to your schedule. All efforts will be made to reschedule as soon as possible.

On rare occasions, one may need to cancel a session due to an emergency: acute illness, accident, hospitalization or inclement weather. There is no charge for a cancellation due to emergency conditions.

THE PROFESSIONAL RELATIONSHIP

The professional counseling relationship is centered on your, the client's needs. I strongly encourage you to let me know if you have any concerns or dissatisfactions with the process. I do welcome your feedback.

I / WE HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION:

Name (please print): _____

Signature: _____

Date: _____

Dr. Beth Hedva & Associates,(RPsych # 3212, RMFT 1106)
6408 Bow Crescent NW, Calgary, AB, Canada, T3B 2B9 TEL 403-247-1441
www.drbethhedva.com email beth@drbethhedva.com

Dr. Beth Hedva & Associates

CONFIDENTIALITY

All Associates and staff sign a confidentially agreement; and all client information and any other information of a private or sensitive nature is considered confidential. Confidential information shall not be used nor disclosed unless you grant me specific permission to do so, with the following exceptions:

There may be times when it is important that I consult with other professionals such as your family doctor or another health professional, teacher or family member. No such consultation will occur without a specific reason nor without your written authorization. Additionally, as part of ongoing good case management and professional practice, I may consult with other counseling professionals for clinical consultation, advice and information. In such case, your anonymity will be maintained, and identifying data will be altered to ensure that confidentiality is maintained.

I consider the personal information we discuss to be strictly confidential, and there are a limited number of circumstances where I may be legally required to disclose confidential information, and may do so without your permission. The exceptions to confidentiality are as follows: :

1. I am required by law to release your records if they are subpoenaed by court.
2. If you are a minor, parental consent is required for me to meet with you. Conditions of confidentiality regarding minors need to be negotiated with a parent/guardian.
3. If I become aware that you have plans to harm yourself or another person, I have the legal obligation to notify appropriate authorities to ensure your or someone else's safety.
4. If information is disclosed that a minor child is being sexually and/or physically abused, I have the legal obligation to contact the appropriate authorities with this information. I would encourage and support you in making the disclosure yourself, but in the event that you were unable or unwilling to do so, I would have to proceed to report both the abuse and the source of information.

   These are the only conditions in which confidentiality cannot be maintained.

RELEASE OF INFORMATION

Please provided any name(s) of professionals you may like me to share information with, consult with, or engage in treatment planning to better serve your needs. (feel free to add more pages).

"I authorize the release of my confidential protected health information as described below:

Person Authorized to receive Disclosure _____ Tel:_____

Patient's Name :_____ Tel:_____

Signature:_____ DOB_____ Today's Date_____

Parent, Guardian or Representative_____ DOB_____ Today's Date_____

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