HEAD TO TOE HEALTH CENTRE

Psychotherapy Intake Form

This confidential information of your medical record and health history will be kept in the Head to Toe Health Centre and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.

Contact Information:

Name: _____ Age: _____

Date of Birth: _____ Gender: : ☐ M ☐ F

Address:_____Email: _____

Phone (H): _____ (W): _____ (C): _____

Emergency contact: _____

Relationship: _____ Phone: _____

Medical doctor: _____ Phone: _____

Address:_____

How did you become aware of the Head to Toe Health Centre: _____

_____

Email/ E-newsletter:

Would you like to receive the Head to Toe Health Centre e-newsletter* to the email address provided?

☐ Yes ☐ No

*Periodically Head to Toe sends out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared.

General:

Have you engaged in Psychotherapy/Psychiatry/Psychology/Counselling in the past? ☐ Y ☐ N

Have you been previously diagnosed with a mental/emotional condition? If so, please describe: _____

_____

Are you presently taking any medication, botanicals, or supplements? If so, please describe: _____

_____

Please list your mental/emotional health concerns or goals in order of importance: _____

_____

_____

HEAD TO TOE HEALTH CENTRE

Patient Agreement Form
Psychotherapy

Your signature below acknowledges the following:

1. *I understand that Psychotherapy is not covered by the provincial gouvernment (OHIP), though may be covered by private and extended insurance plans. Psychotherapy may also be tax deductible.*
2. *The fees and services have been clarified in advance. Payment is due at the end of each visit or each month of visits as the Head to Toe Health Centre is not able to bill insurance companies directly for Psychotherapy at this time. Cash, Cheque, Interac, Visa, and Mastercard are acceptable methods of payment.*
3. *Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 100% of the missed appointment fee.*
4. *I recognize that Psychotherapy is not an isolated system of care and that practitioners welcome teamwork with NDs, MDs, DCs, RMTs, Acupuncturists, and other health practitioners.*

Informed Consent:

As a patient of the Head to Toe Health Centre, I hereby acknowledge that I am willing to provide my practitioner with the information necessary for him/her to fully understand my medical history, presenting symptoms, and the health goals I wish to achieve in our work together. I thereby consent to answering the questions asked of me by my Psychotherapist.

I understand that Psychotherapy is a form of talk therapy and I understand very clearly that Psychotherapy is not a substitute for medical, or psychiatric diagnosis, and treatment.

I understand that Psychotherapists do not diagnose conditions, nor do they prescribe substances, nor interfere with the treatment of a licensed medical professional. It is recommended that I see a licensed physician, or licensed health care professional for any physical, or psychiatric ailment I have.

I understand that Psychotherapy can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

As with all forms of therapy, I understand that Psychotherapy also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect my practitioner at the Head to Toe Health Centre to be able to anticipate and explain all risks and complications prior to treatment.

I understand that the Head to Toe Health Centre will keep a record of my personal health information and of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that the Head to Toe Health Centre will act as the Health Information Custodian for my personal and health information. If I am seeing more than one practitioner at the Head to Toe Health Centre, I imply consent for them to share and discuss my file as deemed necessary by the practitioners, to ensure that I receive care most appropriate for my condition.

With this knowledge, I voluntarily consent to Psychotherapy and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient name (Please print): _____

Signature of Patient or Guardian: _____ Date: _____