Michelle L. Ranson, PhD
Registered Psychologist (#3050)

Acknowledgement of Informed Consent
and Authorization for Treatment

Welcome to my practice! What follows is important information about counseling and psychotherapy, and about my practice policies more specifically. Please read the following and provide your signature, where requested, to indicate your understanding of this information and your agreement with the specified terms. If you have any questions or concerns about anything on this form, please do not sign the form until you have (a) discussed your concerns with me and (b) received a satisfactory explanation.

My qualifications. I am licensed as a Registered Psychologist by the College of Alberta Psychologists. The College verifies the legitimacy of the formal education and training undertaken by its approved psychologists and further evaluates their competency for professional practice through written and oral examination. My formal education includes an earned Ph.D. in Clinical Psychology from Fielding Graduate University (accredited by the American Psychological Association), and two earned master's degrees in (a) Counselling and (b) Clinical Psychology. My Bachelor of Arts degree is in Communications.

Length and frequency of treatment. Counselling typically involves regularly scheduled sessions, usually 50 minutes in length, and usually occurring weekly. The duration of counselling varies depending on the nature of your problem, your individual needs, the complexity of the issues involved, the strength of our working relationship, and your investment in working on the issues both in, and between, sessions. I generally work within a short-term dynamic model; the vast majority of my work with clients wraps-up successfully in somewhere between 2 and 20 sessions.

Confidentiality. Notwithstanding the following exceptions, all information shared with me during the course of our work, including information that could reveal your identity, will be kept in strict confidence and will not be disclosed to any other party without your written consent. When disclosing information to others, I will carefully discuss with you, in advance, the purpose of the disclosure and the information that will, and will not, be shared. If I choose to discuss your treatment with a colleague, I will take pains to disguise any information that could lead to your identification and will assign you a pseudonym.

Exceptions: By law, confidentiality is not guaranteed in situations I deem as possessing life-threatening risk to you (e.g., a threat of suicidal intent) or others (e.g., a threat of homicidal intent), or in circumstances where children or dependent adults are deemed to be at risk (e.g., by sexual or physical abuse, mistreatment, or neglect).

Minors. Please be aware that exceptions to confidentially apply to personal information disclosed in session by minors (children and adolescents). I will discuss these exceptions with you, as applicable. They are also detailed on the "Consent to the Treatment of a Minor Child" form, available upon request or on my website at this link: https://static1.squarespace.com/static/5263d585e4b0a21db5cd819a/t/53a7b193e4b0b50b4e492a12/1403498899413/Consent+to+the+Treatment+of+a+Minor+Child.pdf

Healthcare collaboration. When receiving a referral from another professional, it is customary to acknowledge the referral at the beginning of treatment. When referred by a health care practitioner, such as a physician, it is also a courtesy to send a treatment summary at the conclusion of therapy. In providing your signature, at the bottom, you acknowledge giving your consent for each of these communications, as applicable. If you do not consent to my contacting the referral source, please strike through this paragraph. Understand that you may withdraw your consent to my communication at any point across our professional association.

Medical evaluation and medication. As a psychologist, I do not possess a license to practice medicine, nor do I have prescriptive privileges. Physical and psychological symptoms often interact. however, and I will encourage you to seek medical consultation, wherever warranted. Additionally, medication may sometimes be helpful in alleviating psychological distress and, when applicable, I may suggest you seek medical consultation around prescriptive options and your potential to benefit. I will also respect your preference not to take medication, when expressed.

Recording session information. Professional standards require that *progress notes (or case notes)* be kept for each case. They exist for the purposes and benefit of the therapist, to better facilitate effective case management. Importantly, there is no requirement that case notes be kept in a manner or format that would make them useful, meaningful, or interpretable to any other party. My very brief (a sentence or two) case notes are hand-written after each session and collected within your case file. Pertaining to your case, this information is also considered to be privileged content (i.e., confidential) and may not be shared with any other party without your written consent. Case files are stored in a private, secured location within a locked file cabinet. You may review the contents of your file upon request.

Fee policy. My fee for an individual session is $200/hr. My fee for a couples session or family counselling is $220/hr. These fees are in accord with the rates recommended by the Psychologists' Association of Alberta. Additional time beyond the 50-minute counselling hour is billed in 10-minute increments. Billable services include: face-to-face, telephone, email and/or text message consultation; report-writing and other requested correspondence; provision of copied file content, written case summaries or individual session summaries to other professionals; review of written records from other professionals.

Payment methods. *Fees are payable at each session.* Acceptable methods of payment include cash, personal cheque, debit card, Interac e-transfer, Visa, MasterCard, Apple Pay, or Google Pay.

Court cases and legal issues. If you are involved in litigation of any kind and you inform the Court, or its representatives, that you are in counselling (making your mental health an issue before the Court), you may be waiving your right to keep your records confidential. If the Court subpoenas me, or my file(s), I am obligated to respond to the subpoena. This may mean that I will have to appear before the Court to answer questions, or prepare a summary of your work with me, or release your file in its entirety. There will be a charge to you for the time involved in my preparing for, or appearing for, legal matters, even if I am subpoena's or called to testify by another party. *Because of the complexities of legal involvement, my hourly fee for preparation and attendance at any legal proceeding is $500/hr.*

> **Disclosure of illegal activity.** If you disclose to me that you have done something illegal, I am *not* legally obligated to report your disclosure to the authorities, unless the circumstance involves child abuse, abuse against a dependent adult, or direct threat to another (as outlined above, under *Confidentiality*).

Statements/receipts. I will provide you, at the end of each session, with a receipt indicating the amount you have paid for that day's session, unless we make some other explicit arrangement. If you carry insurance to cover all or part of the cost of treatment, you are responsible for filing insurance claims for reimbursement of the fee. The receipt provides all the information generally requested by most insurers; however, in the rare event your insurer requires additional information to complete your claim, I will provide them with the requested information only after obtaining your consent to release to them the specific information they require.

Phone and emergency contact. I generally do not provide counseling over the phone or by email or text message. It is important to focus on issues *during the therapy hour,* where relevant details can be fully explored and understood, and thoroughly and properly addressed. Brief exchanges between sessions do not allow for full

exploration of the important aspects of any circumstance. If you have an emergency situation that cannot wait until your next appointment, please consider calling to schedule an "emergency session." I will make every effort to see you at my office as quickly as possible. Alternatively, if you need help in an urgent situation, you can find help at the Emergency Services numbers of Foothills Memorial Hospital, or Rockyview General Hospital, or by phoning 911.

Questions and complaints. You have the right to understand what is going on in your counselling at all times. A competent therapist should be able to account for the therapeutic benefit of everything that occurs in a session and across the course of the therapeutic relationship. If you are concerned that you are not benefitting from the time you are investing in counselling; or are confused about, dissatisfied with, or offended by anything occurring in a session, I urge you to express your concerns to me directly; I promise to do my best to understand your position and to pursue a mutually satisfactory resolution. If you are aware of something I can do differently to be of more, or better, help to you, please let me know.

Risks and benefits. Counselling can have benefits and risks. Since counselling often involves discussing unpleasant aspects of your life and/or exploring issues that have not been previously, or readily, talked about, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, disillusionment, and helplessness, and/or your relationship(s) may feel strained. On the other hand, counselling has been shown to have measurable benefits for people who go through it, often leading to improved relationships, providing solutions to specific problems, and significantly reducing feelings of distress and other negative emotions. There are no guarantees around what you will experience, negatively or positively; however, every effort will be made to be sensitive and responsive to your tolerance levels, and to foster the attainment of your identified goal(s) for therapy.

Freedom to withdraw. You have the right to end therapy at any time. Upon your request, I will assist you with a referral to other qualified psychotherapists.

24-hour Cancellation Policy: If you need to cancel an appointment, please notify me by telephone or text message (403-608-3489) *at least 24 hours in advance* of your scheduled appointment. Please understand that, by booking an appointment, you are "renting" my time, in addition to securing access to my expertise. The purpose of a cancellation policy is to allow me time to fill the appointment with other clients who may be waiting, as my availability is often limited.

There is a charge for missed appointments, and for appointments that are cancelled with less than 24 hours notice. Please be aware that third-party payers (such as insurance carriers) will not usually reimburse cancellation charges, and you will thus be fully responsible for these fees.

(Please Initial Here): ___________ *I am aware of and agree to pay the late cancellation/missed appointment fee in the event that I cancel an appointment with less than 24 hours' notice. I am aware that the charge for a missed appointment is the same as my fee for an hour of counselling, pro-rated by the amount of time booked.*

Collections and confidentiality. In the unlikely event that your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

(Please Initial Here): ___________ *I am aware of and take responsibility for the fact that my confidentially may be compromised in the event that my account remains unpaid for more than 60 days (in the absence of mutually agreed upon payment arrangements) and legal means for securing payment are pursued by this psychologist.*

Your Acknowledgement of Informed Consent and Authorization for Treatment

I have read and understood the policies and conditions outlined in the preceding statements. I have had the opportunity to ask questions about them, and I am satisfied that my questions and concerns have been satisfactorily addressed to the extent possible. I agree to enter a professional counselling/psychotherapy relationship with Dr. Michelle L. Ranson and accept the help offered with full knowledge and understanding of these policies, conditions, potential risks and potential benefits.

(Name – Please Print) (Date of Birth – MM/DD/YY)

(Signature) (Date)

(Address)

(Name – Please Print) (Date of Birth – MM/DD/YY)

(Signature) (Date)

(Address)

Michelle L. Ranson, PhD
Registered Psychologist

The information you provide on this form will not be disclosed to anyone (including those who may attend counselling with you) and will be kept as part of your confidential file. It is not required that you answer all questions; however, your thorough completion of the questionnaire is strongly encouraged, as your responses enable me to make a more thorough, focused assessment in support of more efficient treatment planning.

GENERAL INFORMATION

Name: ____

Age: ______ Date of Birth_______________

Address:____
(Street) (City) (Postal Code)

Home Phone________________________________ Cell Phone____
(May we leave a message for you here? ❑yes ❑no) (May we leave a message for you here? ❑yes ❑no)
Employer:____ _____ How long have you been there):_________________

Occupation: ____ _____ Average hours worked per week:________________

Are you content in/with your current employment? ❑ very ❑ moderately ❑ very little ❑ not at all ❑ not sure

Work Phone___________________________________ Preferred Email Address:___________________________________
(May we leave a message for you here? ❑yes ❑no) (May we contact you here? ❑yes ❑no

If contact is necessary (for appointments, etc.), which do you prefer: ❑ Text Msg ❑ Email ❑ Phone Call (circle): home | work | cell | other___________

Last year of school completed: 9 10 11 12 GED College/University: 1 2 3 4 Graduate : 1 2 3 4 5 6

Certificate/Diploma/ Degree pursued/accomplished ____

Are you currently in school? ❑yes ❑no If so, what level?_______________

RELATIONAL INFORMATION

Current Relationship Status (check all that apply) ❑ single ❑ exclusively dating ❑ engaged ❑ married ❑ living together ❑ common-law ❑ separated ❑ divorced ❑ widowed

Are you content in/with your current status? ❑ yes ❑ no ❑ not sure

If in committed relationship, for how long? ______________ How long have you known your partner? ________________

Partner's Name: _______________________________________ Partner's Age: _______

Specific concerns about partner? (e.g., drinking, anger, illness)____

Number of previous marriages for you? _________ For your partner? __________
If widowed, separated, or divorced, for how long? _______________________

With whom do you currently live? (check all that apply) ❑Alone ❑Spouse ❑Children ❑Parent(s) ❑Sibling(s) ❑Boyfriend ❑Girlfriend ❑Other (please specify) ____

CHILDREN:

First Name	Sex	Current age, or yr. of death	Relationship to you (natural, adopted, step)	Living w/you?	Describe him/her (2-3 words)

Family of Origin Information.
(Please list mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect upon your life [either positive or negative]).

Name	Relationship to you mom, dad, sibling, or step-relations	Current age, or year of death	Occupation	Describe him/her (2-3 words)

PHYSICAL HISTORY

Name of Physician: ____ Phone: __________________________

Address of Physician:____

Is your physician aware of the difficulties that have brought you for counseling? ❑no ❑yes.

Did he/she recommend counseling for you or your partner? ❑no ❑yes.

Are you currently receiving any medical treatment? ❑no ❑yes. If yes, please explain________________________________

____

Please list any conditions, illnesses, treatments, or surgeries (including pregnancies, or related treatments) that might be relevant to your reason for seeking counseling: ____

____

Please list all current medications you are taking, and the reasons. (List even if you seldom use, or take only as needed.)

___________________________ ________ which improves/controls __________________________________ ____________
(medication) (dosage) (reason) (since)

___________________________ ________ which improves/controls __________________________________ ____________
(medication) (dosage) (reason) (since)

___________________________ ________ which improves/controls __________________________________ ____________
(medication) (dosage) (reason) (since)

Please check any of the following physiological symptoms/sensations that apply to you currently, or in the recent past:

❑Headaches ❑Rapid heart rate ❑Dizziness ❑Visual trouble
❑Stomach trouble ❑Weakness ❑Difficulty breathing ❑Hearing noises/voices
❑Insomnia/Waking Early ❑ Tiredness/No energy ❑Trouble relaxing ❑Pain- specify______________________
❑Sleeping too much ❑ Change in appetite ❑Tension ❑Other ___________________________

How has your weight changed in the last 2-3 months? ____

CURRENT STATUS

Please check all of the following circumstantial, psychological, or relational symptoms that apply to you currently:

❑Stress ❑Nervousness ❑Anxiety ❑Panic
❑Worry ❑Fears ❑Guilt ❑Avoiding certain places or people
❑Unhappiness /sadness ❑Moody ❑Apathy/don't care ❑Lack of direction
❑Trouble concentrating ❑Trouble making decisions ❑Hopelessness ❑Lack of motivation
❑Terminal Illness ❑Recent death in family ❑Grief ❑Tearfulness
❑Inferiority feelings ❑Defectiveness feelings ❑Loneliness ❑Self-consciousness
❑Shyness ❑No friends ❑Low self-worth ❑Identity issues
❑Relationship distress ❑Communication breakdown ❑Arguments ❑End of relationship
❑Emotional distance ❑Lack of affection/caring ❑Feeling betrayed ❑lying
❑Physical abuse ❑Emotional abuse ❑Verbal abuse ❑Sexual abuse
❑Infertility ❑Abortion ❑Miscarriage ❑Pregnancy
❑Temper ❑Frustration ❑Aggressive behavior ❑Anger
❑Irritability ❑Racing thoughts ❑Unwanted thoughts ❑Concerns with memory
❑Loss of control ❑Impulsive behavior ❑Self control ❑ Compulsivity
❑Sexual intimacy ❑Pornography use ❑Affair(s) ❑Bad dreams
❑Cynicism ❑Eating problems ❑Body Image ❑Perfectionism
❑Illegal drug use ❑Alcohol use ❑Gambling ❑Shopaholism
❑Prescription drug abuse ❑Compulsive sexuality /deviancy ❑Trauma/disaster ❑Trauma/victim of crime
❑Trouble with job ❑Career concerns ❑Co-worker conflict ❑Chronic lateness or absenteeism
❑ Educational concern ❑Concerns for Child ❑Parenting Issues ❑Blended family
❑Parent—Adult Child ❑Family of origin issues ❑ Aging parents ❑ In-law difficulty
❑Finances ❑Legal Matters ❑Spiritual Concerns ❑ Pre-marital counseling
❑Power struggles (with whom?______________________) ❑Other____

Please indicate on the scale below how distressing your problem(s) are to you. Place an "X" on the line.

Distressed Very Little	Moderately Distressed	Extremely Distressed

Are you currently experiencing any suicidal thoughts? ❑Yes ❑No
Over the past several years, have you frequently experienced suicidal thoughts? ❑Yes ❑No
Have you attempted suicide in the past? ❑Yes ❑No When? ________________________________
Have any of your friends or family ever committed or attempted suicide? ❑Yes ❑No

EXTENDED FAMILY HISTORY OF PSYCHOLOGICAL OR PHYSICAL DIFFICULTIES

	Who? (relationship)	Approx.when?	Hospitalization?	# of Times?
❑Depression			❑ yes	#?____
❑Bi-polar disorder			❑ yes	#?____
❑Schizophrenia			❑ yes	#?____
❑Other psychotic disorders			❑ yes	#?____
❑Physical/Sexual Abuse			❑ yes	#?____
❑Substance Abuse (alcohol/drugs)			❑ yes	#?____
❑Eating disorder			❑ yes	#?____
❑Chronic illness /terminal illness			❑ yes	#?____
❑Accidental or untimely death			❑ yes	#?____
❑Unknown mental illness			❑ yes	#?____
❑Other ______________			❑ yes	#?____

PRESENTING ISSUES AND GOALS

Please describe briefly why you are coming for counseling? (i.e., what are your issues, problems?) ________________________

____

____

What do you hope to gain or change by coming for counseling? ____

____

____

How long do you believe counseling should last? ____

Have you had any previous counseling, psychiatric treatment, or residential/in-patient care? ❑no ❑yes.

Month/Year	Duration	Therapist	Location	Was it helpful?

REFERRAL INFORMATION

Please indicate know how you learned about my practice. Where applicable, please provide name of referral source. (Check all that apply).

- ❑ I am a returning client.
- ❑ Word of mouth (family/friend) ___________________________
- ❑ Another professional (physician, lawyer, psychologist, etc.) ____
- ❑ Pastor/Minister ____
- ❑ Internet search led me to www.MichelleRanson.com
- ❑ Search via *Psychology Today*
- ❑ Link from another website ____
- ❑ Workshop, seminar, retreat
- ❑ Other ____