

---

**ADULT CONSENT FOR ASSESSMENT/TREATMENT**

Resilience Psychotherapy, Counselling, Consultation, and Research Corp. has my consent to assess my psycho/social/emotional condition, make a assessment, and formulate a treatment plan and to render counselling as needed to achieve the goals of the treatment plan.

Alaa Eldin Ghazal  
Client Full Name:

---

Date: 31/08/2025

---

Signature: Alaa Eldin Ghazal

---

**RESILIENCE PSYCHOTHERAPY, COUNSELLING, CONSULTATION, AND  
RESEARCH CORP.**

**Consent Form for Psychotherapy/ Assessment Services**

I, \_\_\_\_\_, hereby request and agree to participate in individual psychotherapy at the Resilience Psychotherapy, Counselling, Consultation, and Research Corp..

I understand that psychotherapy requires that I discuss my problems and difficulties with a psychotherapist, who will endeavor to provide a supportive, empathic environment and listen attentively. He may pay particular attention to my feelings, thought patterns, and ways of interacting in the world and may point these out to me so that I may gain increased understanding and awareness of how events in my life are impacting on me. The psychotherapist will not offer advice or solutions to the problems that I am confronting but will try to assist me to come to the best decisions and solutions for my situation.

- I understand that I am free to ask questions about treatment at any time throughout the treatment process.
- I understand that treatment is likely to help but that this cannot be guaranteed in my case. If treatment is not effective, I understand that I will be referred for further treatment if I wish.
- I understand that talking about my problems and difficulties may be difficult and painful at times, and that I may feel distressed during treatment.
- I understand that I can withdraw from treatment at any time and that if I withdraw, another appropriate alternative or referral will be provided if I wish to continue psychotherapy.
- I understand that treatment is provided by Interviewer.
- I understand that by attending and participating in sessions, I am giving my consent for psychotherapy services.

**Confidentiality**

I understand that all information regarding my treatment (including all verbal and/or written exchanges) will be kept confidential, except under the following circumstances. In each of these circumstances, my psychotherapist will endeavor to notify me of the need to break confidentiality:

- If I indicate that I may be a danger to myself or others.

- In the case of apparent or suspected abuse of a child under 16.
- If a known sexual perpetrator is in close contact with a child under 16.
- If I report sexual abuse on the part of a health care professional.
- If my records are subpoenaed by a court of law.
- If the records of my psychotherapist are randomly audited by the College of Registered Psychotherapists of Ontario CRPO ·

I understand that in order to maintain my confidentiality, my psychotherapist will not initiate contact with me in any private or public setting outside of treatment. Rather, I can initiate any contact outside of therapy based on my level of comfort. I understand that it may be advisable to not initiate contact in the presence of others in order to maintain my confidentiality.

I understand that my consent is required for communication regarding treatment with others, including other health care professionals. I understand that this consent can be provided verbally or in writing, but that my psychotherapist's policy is to obtain my written consent whenever possible.

### **Fees for Service**

The fee is CA\$205 plus GST per 50-minute session and is covered by IFHP. Payment will be claimed directly from your insurer, and you are required to sign any documents necessary to process the claim for services provided. By giving this consent, you authorize us to contact the insurance provider on your behalf.

### **Cancellations and Missed Appointments**

I understand that I am required to give 48 hours' notice for appointment cancellations or changes to offer my appointment time to another client. I understand that if I cancel an appointment within this 48-hour period, or miss a scheduled appointment, I will be billed for the session.

### **Contact**

I understand that I can contact my psychotherapist Therapist by email at or by phone at phone. Messages will be responded to during business hours.

My signature indicates that I have read and understood the contents of this form that I have had the opportunity to ask questions, and these questions have been answered to my satisfaction, and that I freely agree to participate in individual psychotherapy.

---

<b>Client</b>	<b>Therapist</b>
Name	Name:

---

Resilience Psychotherapy, Counselling, Consultation,  
and Research Corp.  
406-111 Waterloo St., London ON N6B 2M4  
Tel: +1 (548)866-0366 Fax: +1(226) 916-0283  
Email: [aabojadi@resiliencecc.com](mailto:aabojadi@resiliencecc.com)  
Website: [www.resiliencecc.com](http://www.resiliencecc.com)



---

Date 31/08/2025

Signature Alaa Eldin Ghazal

---

Date 31/08/2025

Signature Alaa Eldin Ghazal

---