Client Contact Details

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_

Age \_\_\_\_\_\_ Male ( ) Female ( ) Ethnicity\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province\_\_\_\_ Code \_\_\_\_\_\_\_\_

Phone 1 (home/work/cell circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2 (home/work/cell circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 3 (home/work/cell circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 4 (home/work/cell circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Goals

I am seeking service for the following purpose(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I will choose the goals of this service (though I may be guided in my goal selection).

Risks of psychotherapy

I understand that there is no guarantee of a successful outcome from psychotherapy and that there are some risks, such as facing unpleasant memories, experiencing difficult emotions, changing self-perceptions, trying out new behaviours, and changing ways of relating to others.

Voluntary participation and ending

My participation in this service is voluntary. I may refuse to engage in any activity, to ignore any advice and end my involvement at any point and for any reason. I understand that if progress has not been obtained Dr. Miller may end the therapy and will help me find alternative services.

Process of psychotherapy

I understand that I will receive Mind-Body Attunement Therapy which is a body-based therapy to resolve dissociated emotional distress.

I expect this to take roughly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sessions. We will meet \_\_\_\_\_\_\_\_\_\_\_\_\_\_ times each

\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We will review the effectiveness of treatment every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sessions. (To be discussed during the Service Enquiry Discussion).

Payment

I agree to pay for all psychological services provided to me at a rate of $ \_\_\_\_\_\_\_\_\_\_\_\_\_ per 50 minute session at the

start of the session.

I will not be charged if I cancel sessions with more than 24 hours advance notice. For sessions I cancel with less than 24 hours advance notice, or fail to attend, I will be charged in full even if this amount is not covered by any third-party funding arrangement.

When payments are not made according to this agreement all further sessions will be cancelled and reports will be withheld until all accrued fees have been paid in full.

Notes

I understand that clinical notes will be taken for the purpose of providing therapy. I will not request these notes for court purposes.

Confidentiality

I understand that the process of psychotherapy is confidential. I also understand that confidentiality is waived in rare cases when significant harm or death of myself or another person might be avoided or to comply with the law.

Complaints

I understand that I can make a formal complaint about the process of therapy to the College of Psychologists of British Columbia, 404-1755 West Broadway, Vancouver, BC, V6J 4S5.

Contract agreement

I have carefully reviewed this document and can access a copy of it on [www.DrKevinMiller.ca](http://www.DrKevinMiller.ca). I have had the opportunity to ask any questions or concerns arising from it. Based on this information I hereby give my consent to participate in therapy

Signed: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client

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Witness