

Adult Psychotherapy Consent Form

Patient Name	:	Aswathi Vipin			Emirates ID	:	784-2543-5254612-1	
File No	:	1	DOB	:	1991-11-21	Nationality	:	Indian
Gender	:	Female	Doctor's Name	:	Amirtha Patel	Date	:	2024-04-30

Welcome to the VISION MEDICAL & DENTAL CENTER (Abu Dhabi). As part of our therapeutic working relationship, we wish to make clear the rights and responsibilities we share. The following is intended to provide you with information concerning the manner in which this center operates. Please read the following information carefully. If you have any questions, please do not hesitate to bring them to the attention of your therapist. Psychologists are required by law to provide this information to patients.

ADMINISTRATION OF PRACTICE

At the VISION MEDICAL & DENTAL CENTER (Abu Dhabi), we are a team of licensed psychologists registered by the Dubai Health Authority. We are also licensed in the country where we completed our training and abide by the rules and regulations guiding ethical practice set out by our respective psychological organizations. Should you have any complaints regarding the service you receive, do not hesitate to bring your concerns to the attention of the clinic director, Dr. Katerine LeMay, Ph.D., C. Psych..

FEES AND DURATION

Psychotherapy typically takes place over a period of time. The number of sessions depends on the recommendation of the clinician and is normally 50 minutes in duration per session. Fees for all clinical services are billed at an hourly rate and paid at the end of each session by credit card, cheques are not accepted. Further, regarding insurance companies, services are on a pay-and-claim basis, consequently, all claims will have to be put through by you. To assist us, kindly bring along your claim form and present it to your therapist at the beginning of the session.

APPOINTMENT CANCELLATION POLICY

The appointment time is held exclusively for you. If you arrive late, the session cannot be extended. The session will be charged in full if we don't receive the cancellation within 24hrs of the appointed time. Insurance does not pay for any part of missed appointments.

COMMITMENT TO CHANGE

Effective psychotherapy requires a commitment to change. As with other efforts, you will get out of it what you put into it. Our therapists value building a safe, confidential, and non-judgmental therapeutic relationship to facilitate the exploration and resolution of difficult feelings, emotional reactions, and problematic thoughts and behaviors negatively impacting your life. Should you feel that your needs are not being met, we ask that you discuss these with your therapist. You are free to terminate services at any time. Should you wish to do so, please inform your therapist so that your file may be closed, and any planned appointments cancelled.

QUESTIONNAIRES

You may be asked to answer one or more questionnaires. The purpose of this is to help in your assessment and to provide additional information that will help in your treatment. You are not obligated to answer these questionnaires.

BENEFITS AND RISKS ASSOCIATED WITH PSYCHOTHERAPY

Benefits include emotional support, improved mental health, enhanced self-awareness and personal growth, improved relationships, and support during life transitions. It provides a safe space for individuals to express themselves, work through mental health concerns, and develop coping strategies. Psychotherapy can lead to positive changes, increased self-acceptance, and better communication skills.

However, there are risks and limitations to consider. Engaging in therapy can evoke discomfort as individuals confront difficult experiences. Immediate solutions should not be expected, as therapy is typically a gradual process. There is a small risk of encountering unethical practitioners, so it's crucial to research and choose qualified professionals. Therapy requires a commitment of time, energy, and financial resources. It may not be the sole solution for every mental health concern, and some conditions may require additional interventions. It's important to have open communication with your therapist to discuss potential benefits, risks, and individual concerns before starting therapy.

CONFIDENTIALITY

The matters you discuss with your therapist are, except in highly unusual circumstances, completely confidential. Information about your situation will not be divulged to anyone without your permission. There are, however, situations in which confidentiality cannot be maintained:

1. If your therapist believes that you are at serious risk of harming yourself or someone else.
2. If your therapist receives information about child abuse (physical, sexual, emotional), or neglect.
3. If ordered to do so by the court, the Dubai Health Authority, and the Community Development Authority, your therapist or clinic management must surrender the information they request.
4. If your therapist receives information about the inappropriate sexual conduct of a regulated health professional.
5. If the Dubai Health Authority and or the Community Development Authority requests to see your file during a facility inspection.

We would like to inform you that data breaches may occur unexpectedly when using online video platforms, emails, and social media. Should you communicate personal information using these modes of communication we will assume that you have made an informed decision.

Our clinicians may consult with other professionals about your case. These individuals are bound to a confidentiality agreement with the VISION MEDICAL & DENTAL CENTER (Abu Dhabi). Patients ar consent providers have the right to refuse such agreements.

By signing below, I attest that I have read and understood the information written on both pages of this document and that a copy has been provided to me for my personal records.

DEMOGRAPHIC INFORMATION

Thank you for completing this questionnaire. Please note that the information gathered remains confidential and is only used for the purpose of providing services.

Relationship Status :ddg Preferred language for session:fdf How long have you been living in Dubai?dg

Insurance provider : Al Buhaira

Did a physician or psychiatrist refer you? ☒ Yes ☐ No

If yes, please provide their name: : dfdg

Type of service:

☒ Individual ☒ Couples Therapy ☒ Single Consultation ☒ Other

Preferred means of contact: ☒ Mobile ☒ Whatsapp ☒ Email

First time seeking therapy? ☒ Yes ☐ No

EMERGENCY CONTACT:

Name:dgd Mobile Number:dgd Relationship:dgg

Were you ever prescribed the following:

Anti-depressants ☒ Yes ☐ No



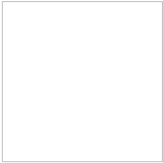
If yes, please specify the : dgd date and duration: 3/9/2024 12:00:00 AM

Anti-anxiety ☐ Yes ☐ No

If yes, please specify the : dgd date and duration: 3/16/2024 12:00:00 AM

Other : dfdf

Describe your physical health in general (Do you have pain, suffer from irritable bowel syndrome or other digestive problems, heart problems, etc.):dggd

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	witness	Doctor
		
Patient Name Aswathi Vipin Date 2024-04-30	Witness Name dg Date 2024-04-30	Doctor's Name Amirtha Patel Date 2024-04-30