



## London Middlesex Counselling & Addiction Services (LMCAAS)

### CONSENT FOR TREATMENT SERVICES

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

The Counselling services provided at LMCAAS are carried out by either a registered social worker and/or psychotherapist.

Risk and benefits: I understand that there may be some risk and benefits while engaging in the therapeutic services offered by LMCAAS. I understand that by participating in these services may cause me to recall unpleasant memories and events which may induce painful, stressful and unpleasant emotions. I understand that these feelings may impact my current relationships with others. However, I also understand the potential benefits such as new skills and strategies by which I may increase my tolerance to stress, increase effective communication, develop more self-regulations strategies and also increase my self-awareness and self determination. As well I understand that this discomfort may also lead to growth and the developed of greater resiliency.

Confidentiality: I understand that all information that is disclosed during my involvement with my LMCAAS therapist is confidential and may not be revealed to anyone without my expressed permission. I further understand that confidentiality **cannot** be maintained by the LMCAAS Therapist when:

1. I present a serious danger to myself or to others
2. When there is an indication of child abuse, confirmed or suspected (past or present).
3. A court order is made requesting information and/or clinical records about my counselling or therapy

I understand that in addition to the above mentioned limits to confidentiality Social workers and psychotherapists practicing in Ontario have further limits to confidentiality which will the LMCAAS therapist will explain to me before I consent to treatment.

Professional Regulations and Clinical Records: I understand that members of LMCAAS are obligated to keep a written record of our meetings, which includes information detailing discussions during our sessions. These records are securely stored and will be made available to me upon my request. I understand that members of LMCAAS may disclose information about my counselling sessions to his or her professional colleagues or clinical supervisor. These consultations can help my counsellor or therapist to understand me more fully. I understand that the clinical records kept by Social Workers, Psychotherapists and/or Psychologists are subject to review by pertinent regulatory and/or licensing bodies. This is done in order to ensure client rights are being protected and professional standards are being maintained.

This consent to treatment will be effective for the duration of my treatment with LMCAAS.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_