



**Psychotherapy Intake Form**  
Jordan Smith, MSW, RSW Psychotherapist

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Postal Code** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Can we leave a message?** YES / NO

**Email** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Relationship to Emergency Contact** \_\_\_\_\_

**How did you hear about my services?** \_\_\_\_\_

**Family Doctor** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Additional Health Care Providers** \_\_\_\_\_

**Current Medication & Dosage** \_\_\_\_\_

**Is insurance or any other third party involved in your care:** YES / NO

If yes, who: \_\_\_\_\_

**Previous psychotherapy?** YES / NO If yes, when: \_\_\_\_\_

**Briefly describe what led you to seek support today:**

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



## Informed Consent for Psychotherapy Services

I, \_\_\_\_\_, hereby request and agree to participate in individual psychotherapy with Jordan Smith, MSW, RSW Psychotherapist at Collective Health Clinic.

- I understand that Jordan Smith is a Registered Social Worker who abides by and adheres to the ethical guidelines and the standards of practice of the Ontario College of Social Workers and Social Service Workers (#81765) and the Ontario Association of Social Workers (#11941).
- I understand that psychotherapy requires that I discuss my problems and difficulties, and that talking about them may evoke uncomfortable and/or distressing feelings at times. I understand that I will be given a safe space to explore these feelings, free of judgement, and will be provided with added resources and support as needed.
- I understand that treatment is likely to help, but that this cannot be guaranteed.
- I understand that I can withdraw from treatment at any time, without consequence, and that I will be provided with additional resources and referrals if requested.
- I understand that I am free to ask questions about treatment at any time, without consequence.

### 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:

- If I indicate that I may be a danger to myself or others;
- In the case of apparent or suspected abuse and/or neglect of 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;
- I understand that my written consent is required for all communication with others, including other health care professionals, insurance companies, and/or family members. I understand that I can revoke this consent at anytime during treatment, and upon the termination of treatment, all consents will become invalid.
- I understand that Jordan participates in monthly clinical supervision and that clinical supervision is necessary in order to adhere to the ethical standards of practice. I understand that there may be times when Jordan, without using identifying information, will seek advice and support about my case, to the benefit of me.



- I understand that in order to maintain confidentiality, Jordan will not initiate contact with me in any public setting outside of treatment, unless I initiate contact based on my level of comfort.

### **Fee for Service**

- I understand that the fee for psychotherapy services is \$115.00 for 60 minutes, and payment is due at the end of each session. I understand that fees are subject to change based on the College standards and cost-of-living. I understand that Jordan will disclose any fee changes with advanced notice.

### **Cancellations and Missed Appointments**

- I understand that I am required to give 24 hours notice for appointment cancellations or changes, in order to offer my appointment time to another client. I understand that if I cancel an appointment within this 24-hour period, or miss a scheduled appointment, I may be billed for the session.
- I understand that during inclement winter weather, sessions are automatically cancelled on days when Dufferin County schools are closed, and that sessions scheduled on No Bus Days, will be subject to cancellation. I understand that Jordan will communicate all schedule changes with as much notice as possible.

### **Contact Information**

- I understand that I can contact Jordan by email ([jordansmithrsw@gmail.com](mailto:jordansmithrsw@gmail.com)). I understand that email cannot be guaranteed to be confidential, and that it is used for administrative purposes only, such as cancelling a session. I understand that I can call Jordan (519-941-3100) and messages will be responded to within 24 hours and during business hours only.
- My signature indicates that I have read and understood the contents of the consent 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.

**Client Name:** \_\_\_\_\_ **Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Therapist Name:** \_\_\_\_\_ **Therapist Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_