Nourishing Health Mind, Body & Emotion Therapy

Suite 103-179 McDermot Avenue, Winnipeg, Manitoba| R3B 0S1 |204-218-6836 | www.NourishingH.com
Megan@NourishingH.com

Client Information & Intake Form

Date: ____________________

Full Name: ____________________

Address: ____________________

Home Phone: ____________________ Is it ok to leave a message: Yes No

Parents Work Phone: ____________________ Is it ok to leave a message: Yes No

Email: ____________________ Preference of communication: ____________________

Parent Marital Status: ❐ Single ❐ Partner ❐ Married ❐ Divorced ❐ Separated ❐ Widowed

Date of Birth: __________ Age: __________ Gender ❐ Male ❐ Female ❐ X

Grade: __________ School: __________

Who currently resides in the home: ____________________

Any legal involvement (Court ordered custody, CFS) : ____________________

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Primary Concern

Please describe the main concern that brought you to see me:

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Consent to Treatment

The undersigned client consents to undertake mental health treatment with Megan Grant, Registered Psychiatric Nurse. Treatment may be in the form of consultation, mental health evaluation or therapy services. There are many different methods of treatment that I may use to address the problems you wish to discuss with me. Participating in therapy can result in various benefits to you including: developing personal insight; reducing emotional distress; fostering healthy relationships; improved sense of well being and resolving other specific concerns. Therapy can have risks as well. During the therapy, you may experience uncomfortable feelings, or you may experience unexpected consequences. Therapy requires openness and your active involvement. You are encouraged to provide feedback and input about the course of your therapy as it proceeds. While success cannot be guaranteed, therapist and client join together in a good faith interest in meeting the goals of the client.
Over the first several sessions a specific treatment plan – including goals, techniques and frequency of visits – will be discussed with you, you may ask about alternative treatment for your condition or situation and the risks and benefits of those treatments. If at any point I determine that I am unable to help you reach your therapeutic goals, I will discuss this with you and if appropriate, will develop a plan for termination and a referral to another provider. You have the right to terminate your therapy at any time. The therapeutic relationship between client and therapist never involves social, sexual, or business relations or any dual relationship that may impair the effectiveness of treatment.

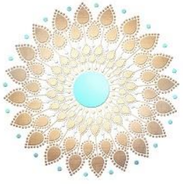
Confidentiality

The client/therapist relationship is held in the strictest confidence. Any information disclosed with this relationship and the written records pertaining to your treatment may not be released without your written permission, except where disclosure is required by law or my Code of Ethics. I maintain a personal information policy in accordance with the requirements of the Personal Health Information Act (PHIA). I ensure my clients understand that to provide therapy services I must obtain personal information in accordance with the purposes as set out in this policy; which include the following: (1) Maintaining complete and accurate client files and complying with the requirements of the College of Registered Psychiatric Nurses of Manitoba guidelines for RPN's in independent practice; (2) Providing electronic services such as contacting by email/text/phone. Clients understand and consent that: (1) Personal information will not be used or disclosed for purposes other that those for which it was collected except with written consent or where disclosures are required by law, and (2) Each client has the right to view upon written request their own personal information and have it amended if inaccurate or incomplete. (3) Every reasonable effort will be made to maintain confidentiality while using text/email/Zoom sessions, however the signed below agrees that any virtual communication may pose a risk to the breach of health information; signing below indicates your full consent into virtual communication and that you are aware of risks associated with same.

Acknowledgment

My signature below indicates that I have read the entire agreement and consent to the above statement of policies as a condition of received services.

Print Name	Signature (Client or Guardian)	Date



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Fee & Cancellation Policy

1. Fees are set on an hourly (55 minute) basis. Payment is expected at the time of your session.
2. My services may be covered by third-party health insurance policies. Insurance companies often have a maximum amount that is covered per year or pay only a portion of the fee per visit. Check with your insurance company to be sure you understand your coverage.
3. You are responsible for knowing the limits of your policy.
4. There will be no charge for a cancellation made at least 24 hours before the scheduled appointment.
5. Sessions cancelled the day of the appointment will be billed at fee of $150 per hour.
6. The full fee will be charged for failing to cancel an appointment.
7. At the initial assessment it will be required to have a credit card on file to be charged for appointments cancelled under 24 hours or for no shows. Your signature on this document agrees to the charging of your credit card in the event of a no show or cancellation under 24 hours.
8. Telephone calls exceeding 10 minutes, other than initial consultation, will be billed proportionately; as will professional telephone consultations (physicians, school personnel, lawyers) exceeding ten minutes. These services will be billed proportionately at the hourly rate and undertaken only with written consent.
9. Written reports to other professionals or third parties (e.g. insurance, government agencies) will be billed proportionately at the hourly rate and undertaken only with your written consent.

I have read the above and I agree to the terms outlined and agree to have my credit card information shared and charged as per the above outlined expectations

Signature of the party responsible for payment

Print Name Signature (Client or Guardian) Date