London Middlesex Counselling & Addiction Services (LMCAAS)

CONSENT FOR TREATMENT SERVICES

Name _____ Address_____ DOB _____

Counselling services provided by a LMCAAS therapist is a service provided by the London Middlesex Counselling and Addiction Services (LMCAAS). The LMCAAS Therapeutic Counselling services carried out by a registered social worker and/or psychotherapist.

☐ Risk and benefits: I understand that there are risk and benefits while participating in the therapeutic services offered by LMCAAS. I understand that by participating in these services may involve my recalling of unpleasant memories and events and may cause strong emotional feelings which may induce painful, stressful and unpleasant feelings. I understand that these feelings can impact my relationships with others. However, I also understand the potential benefits I may garner to increase stress tolerance, increased self awareness and self determination. As well I understand that this discomfort may also lead to growth and the developed of greater resiliency and self awareness.

☐ Confidentiality: I understand that all information disclosed during my involvement with LMCAAS therapist is confidential and may not be revealed to anyone without my 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 for 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 general information of what we have discussed 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 are subject to review by their respective regulatory and/or licensing bodies. This is done in order to ensure client rights are being protected and appropriate levels of professional standards are being maintained.

This consent to treatment shall remain in effect for one year after the date signed below.

Sign: _____ Date:_____ Witness:_____