TONI CAMPAGNONI & ASSOCIATES INC.
Psychological & Counselling Services

Phone: (902)354-4660
Fax: (902)354-3721
familypsychology@eastlink.ca

Offices: 6 Bridge St., Milton, N.S. & 134 North St., Bridgewater, N.S. Mailing: P.O. Box 228, Liverpool, N.S., B0T 1K0

CONSENT FOR PSYCHOLOGICAL SERVICES

CHILD'S NAME :	**CHILD'S DATE OF BIRTH :**
NAME OF PARENT/LEGAL GUARDIAN :	**NAME OF PARENT/LEGAL GUARDIAN :**
PHONE# : (HOME) **(OTHER)**	**PHONE# : (HOME)** **(OTHER)**
MAILING ADDRESS :	**MAILING ADDRESS :**
EMAIL ADDRESS	**EMAIL ADDRESS**
REFERRAL SOURCE :	**IN CASE OF SEPARATION/DIVORCE, CUSTODY IS :**
COVERAGE PROVIDER :	**COVERAGE LIMIT :**

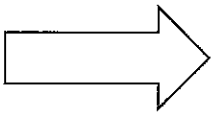
Consent and Confidentiality :

- I agree for myself or my child to receive psychological services from a psychologist* at Toni Campagnoni & Associates Inc. I understand that I will be actively involved in my child's treatment and kept up-to-date on his/her progress. *Psychologist refers to Registered Psychologist or Psychologist (Candidate Register).

- I understand that all information I disclose to my psychologist is held in the strictest of confidence and may not be released without my written consent even after services are terminated. There are some exceptions to this – which are mandated by law. Some exceptions to confidentiality include situations where there is a danger to myself or another person ; actual or suspected abuse or neglect of children/minors or the elderly, or presentation of a valid court order.

- This is a collaborative office and, on occasion, the psychologists consult with one another but information remains confidential. Should this be a concern, please let us know.

- My psychologist may disclose records pertaining to my case to my insurance company for submission and validation of claims. Typically, insurance companies may request dates, duration and types of services received.



TONI CAMPAGNONI & ASSOCIATES INC. -- Phone: (902)354-4660 Fax: (902)354-3721

Payment and Cancellation Policy :
I have been informed of the costs of psychological services ($160.00 per hour). There is a different fee structure for assessments. Our fees are set in accordance with the guidelines put forth by APNS. While the administrative assistant will submit my claim to my insurance company, I understand that I am responsible for the full service fee. If I should fail to give 24-hour notice to cancel an appointment, a fee may be charged.

Signature of parent/legal guardian	Date
Signature of parent/legal guardian	Date
Signature of witness/psychologist	Date

Release of Information

I, _____ for minor: _____ authorize only
name of client/patient — name of minor client/patient

_____
(ie. School, Family Physician, Specialists, etc.)

to disclose/receive solely to/from Toni Campagnoni & Associates, Inc., for the purpose of:

_____
(treatment, referral, consultation, testing, psychological evaluation etc.)

I understand that I have the right to inspect and copy any written information which is disclosed.

I understand that if I do not consent, no information will be disclosed except as provided by law.

This consent is subject to revocation in writing at any time, but such revocation can have no effect on disclosures previously made. In any event, this authorization expires without express revocation upon termination of therapy or on the date indicated below.

Release expiration date: _____

Signature of parent/legal guardian	Date
Signature of witness/psychologist	Date