

M. ALLISON REEVES CLINICAL COUNSELLING INTAKE

M. Allison Reeves, MA - Registered Clinical Counsellor

Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Telephone: (w) _____ (h) _____

Referral source: _____

Family Physician: _____

Medication: _____

Person to notify in case of emergency: _____ Tel No: _____

Fee: _____

Counselling notes, in addition to the information on this sheet (circle) will /will not be kept on file. Initials _____

Insurance coverage? Yes / No _____ Limit _____

Release of Information Agreement

Information obtained within the counselling sessions will not be released without the written consent of all parties or a court order.

Limits of Confidentiality

- If a client threatens bodily harm to self or others
- If there is indication of child abuse
- Counsellors under subpoena are bound by law to disclose information obtained during the course of counselling

Cancellation Policy

24 hour notice of cancellation is requested or the full session fee will be charged. (Includes clients whose fees are paid by 3rd parties who do not cover missed appointments).

Client: _____ Date: _____

Counsellor: _____ Reg.No. _____



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