

Arla Sinclair Counselling Solutions

M.Ed., Registered Clinical Counsellor
1045 Linden V8V 4H3

812 6126 arlasinclair@shaw.ca www.arlasinclair.com

Client Intake Agreement

Name _____ Date _____

Address _____

Phone _____ Ok to leave message _____

Email Address _____

As a Registered Clinical Counselor with the British Columbia Association of Clinical Counsellors, #2193, I offer professional counselling to individuals, couples and groups. Counselling can bring **deeper awareness** and **insight** and sometimes requires that you be **willing** to examine difficult topics, experience stronger emotions, and try out new and different behaviors. I believe that as a counsellor I hold the container, the **safe place**, or open space where my client can think what they think, feel what they feel, say what they want to say and come to know who they are in a deeper way. I believe it is an honour and a privilege to sit with someone and enter their world. My commitment to you is to aid, assist and encourage you in **living your life effectively**.

As a client I understand that all information disclosed in my counselling sessions will be kept confidential with three exceptions:

1. possible clinical consultation with a professional supervisor
2. if I disclose information that leads my counsellor to conclude that a child is in need of protection, my counsellor is obligated by law to report this information to child protection authorities.
3. if my counsellor believes I may do harm to myself or someone else.

In the case of an emergency or imminent harm to myself or another, I give my permission for my counsellor to contact the appropriate authority.

Family Doctor _____ Phone _____

Family / Friend Contact _____ Phone _____

I agree with these guidelines and agree to pay the stated fee for each session. _____

Client's Signature _____

Counsellor's Signature _____