CATHOLIC FAMILY SERVICES OF THE BATTLEFORDS

#101 1272 -101st Street
North Battleford, SK S9A 0Z8
Phone (306) 445-6960 Fax (306) 445-0434
Email: cfs@battlefordscfs.ca

COUNSELLING INTAKE FORM

Date: _____

Primary Client:

Name: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Date of Birth: (MM/DD/YYYY): _____

Phone Number: _____ Can we leave messages at this number? ☐ Yes ☐ No

Email: _____ Address: _____

Family Members:

If additional family member will be joining counselling, please list them below (Names, DOB, gender, and contact information). *If Primary Client is under 18, please list above details for custodial parent(s)/guardian(s).*

Emergency Contact Name and Number: _____

Do you require a registered counsellor for insurance purposes? ☐ Yes ☐ No

If yes, please list details: _____

Once you have paid for your session you will receive your receipt that you can submit to your insurance company.

Reason for seeking counselling:

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Women, Men, and Children can all be victims of violence and abuse. Have you experienced violence and abuse?

☐ Yes ☐ No

If YES, is this current or in the past? ☐ Current ☐ Past

Are you safe today? ☐ Yes ☐ No

Do you have a Mental Health Diagnosis? If YES, please list:

_____

Are you currently prescribed medicine related to the diagnosis? _____

Our Agency strives to serve all people and groups in the community. The following information is collected to help us provide services to all people. We do not release names with the information collected, only numbers.

Family Structure: ☐ Single ☐ Couple ☐ One-Parent Family ☐ Two-Parent Family

Ethnicity Background: _____

Religious Affiliation: _____

Source of Family Income: ☐ One-Wage Earner ☐ Two-Wage Earner ☐ Other

Please sign or type your full name below. By providing your typed name, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

_____ _____

Signature **Date**

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CONSENT TO RECEIVE COUNSELLING SERVICES

Confidentiality

- Confidentiality will be maintained for everyone referred to, or involved with Catholic Family Services (hereinafter referred to as "CFS"). All information shared by the client will be kept private, including records that are maintained within the office.
- In the event that you and your counsellor mutually agree that information about your needs to be discussed with someone outside the agency, you will be asked to sign a consent form agreeing to this sharing of information.
- Confidentiality is subject to the law, and in particular including, but not limited to, the Child and Family Services Act and the Mental Health Services Act, which requires information must be shared without your additional consent when we have a reason to believe any of the following situations exist:
    - A life is in danger
    - A child or elderly person requires protections
    - When a subpoena, warrant or order is issued to obtain information
- CFS staff will not acknowledge clients outside of the office unless initiated by the client. We feel this is necessary to protect the confidentiality of the people we serve.
- When our office calls you, our phone number is blocked for your confidentiality.

Client Rights

- Everyone using the services of CFS has the right to be treated with dignity, equality, respect and recognition of intrinsic worth.
- The best interest of the client will be upheld by CFS at all times, subject by law with all actions working towards what is believed to be of benefit to the client. Together the client and counsellor focus on exploring the presenting issue and available options, with responsibility for decision making retained by the client.
- As professionals, counsellor conduct is guided by CFS policy and the Code of Ethics of their profession. You are invited to ask your counsellor about his/her training and experience.
- We do our best to maintain counsellor continuity. However, there may be circumstances that require changing your counsellor.
- Interns are part of the clinical training program at Catholic Family Services. A qualified intern counsellor may be assigned with appropriate supervision.
- We value client-feedback. If you wish to provide any comments or discuss a concern with someone other than the counsellor, please ask to speak to the counsellor's supervisor by contacting the reception staff.

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Client Responsibilities

- Everyone has the right to be treated with respect. CFS will not tolerate any harassment, abuse or violence toward anyone including clients and staff.
- Please arrive on time for scheduled appointments. If you are unable to attend a scheduled appointment, we require a minimum 24 hours notice in advance, or a full fee will apply.
- If you repeatedly miss scheduled appointments without notification OR if you have more than six weeks of absence without advance discussion with your counsellor, your file may be closed.
- Please advise us of any changes to your address, email address or telephone number.

Fees

- Fees will be waived if you are currently residing at Interval House (Please complete Self-Declaration Form-Counselling Fees)
- Fees will be waived if Primary Client is referred by the Principal of select Light of Christ Catholic School Division Schools (St. Mary's, ÉMBM, Holy Family, Notre Dame, St. Peters, Rivier).
- $35 per session if your household income is below $55,000 (Please complete Self-Declaration Form-Counselling Fees.)
- Walk-in/Call-in Counselling is free and available by booking on the same day depending on counsellor's availability (Please ask the receptionist for more information)
- Fees for telephone or video sessions are the same as in-person sessions. Session length may vary.
- You may be able to claim your counselling fees under "medical expenses" for tax purposes if they reach the annual threshold established by the Canada Revenue Agency. For more information, please contact the Canada Revenue Agency.

Payment

- Counselling fees are due before each session. Fees can be paid through reception by Etransfer at finance.cfs@sasktel.net, credit card, cheque or cash. All prices include GST.
- If payment is not received after two sessions, counselling will be stopped until the balance is paid in full. Walk-in/Call-in Counselling remains available as a free option.

Insurance Claim

- You are responsible to pay us first unless we have a prior arrangement to bill directly. You will receive a receipt which you can submit to your insurance provider for reimbursement. Please be advised that we are not responsible for the decisions of your insurance provider.

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- Please let us know in advance of the specific counsellor credentials your insurance will cover. We will try to match you with a counsellor with the requested credential if possible. If you are unsure, please contact your plan administrator and contact us to schedule your first session.

Counselling via Video or Phone

- Your counsellor has taken the appropriate steps to ensure your privacy and confidentiality. In order to improve your privacy, we recommend taking the steps to participate counselling in a private setting. Headphones are recommended during the session to increase your privacy.

Do you wish to receive counselling via video or phone? ☐ **Yes** ☐ **No**

Please sign or type your full name below. By providing your typed name, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

I (We) the individual(s) listed below (or guardian to those listed below) hereby request counselling services. I (We) have read or verbally heard, understood, and agree to abide by the terms and conditions of services outlined on this form, and consent to receiving counselling services.

Consented to by:

Signature	**Date**
Signature	**Date**

Witnessed by:

Signature	**Date**

** If you are seeking services for children, Parental Consent Form should be completed in addition to current page (see page 4).*

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PARENTAL CONSENT FORM

Name(s) of Child(ren): _____

I, _____ (Name), _____ (Relationship) and legal guardian, warrant that I have the authority to consent for my child(ren) to participate in counselling/group programming offered by Catholic Family Services of The Battlefords Inc. under the mandate of this organization.

I understand that my child(ren) will have the opportunity to share his/her/their feelings, expectations and attitudes about our life circumstances. Should I be included in the counselling, my involvement will focus on ways of helping the child(ren) to adjust more successfully to these circumstances.

I agree that neither myself nor anyone representing me shall call on any Catholic Family Services employee during or at any time after it to provide either written or oral testimony at any examination trial, or application in any court where the marriage, the custody of or access to the child(ren) are in issue or are related to the issues or dispute between me and any other persons, Catholic Family Services does not provide specialized custody/access assessments.

I agree to notify the office of Catholic Family Services should anyone other than myself or _____ i.e.) child attending drop off or pick up the above noted child. Please specify any other relevant information and leaving on his/her own.

Parental Separation/Divorce: (Check One) ☐ Yes ☐ No

If Separated/Divorced, please indicate custody agreement: (Check One) ☐ Joint ☐ Sole

*In the case of a separation/divorce signatures of **both** parents is required. If one parent has sole custody, please provide legal documentation of such. If unable to obtain the second parental signature, please indicate the reason below:

Please sign or type your full name below. By providing your typed name, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Parent/Guardian:	_____	Parent/Guardian:	_____
Signature:	_____	Signature:	_____
Witness:	_____	Witness:	_____
Date:	_____	Date:	_____

Principal Signature ONLY required when primary client is accessing services through Light of Christ Catholic School Division

Principal Name: _____

Principal Signature: _____