Dr. Daniel Chorney & Associates
Psychological Services

5991 Spring Garden Rd Suite #1160, Halifax NS, B3H 1Y6
TEL: 902 444 1160 www.chorneyandassociates.com
FAX: 902 444-3210 drchorney@gmail.com

Client Information and Consent to Services

Services

Psychologists at Chorney & Associates may provide the following services, which may be customized to meet your specific needs or the needs of your family: individual therapy and/or assessment, group therapy, family therapy, couples counseling, and psychoeducational assessments. We provide services to children, adolescents, adults, and families. Please note that no psychologist at this practice specializes in custody evaluations or parental capacity assessments. To provide the best quality of care to our clients, parents in legal/divorce/custody proceedings should be aware that we would not provide any legal opinions about the capabilities of either parent unless required by law. Emergency psychological services should be addressed by your local emergency department or by calling police/ambulance/emergency services (e.g., 9-1-1).

Fees

Psychological services are billed at the rate of $190.00 per therapy hour (50 minute session, with 10 minutes devoted to chart review and progress notes). Additional time and other services pertinent to your care are charged on a prorated basis. Examples of this include longer session times (e.g., if 1.5hrs is needed or desired), report writing, attendance at meetings or school visits, extended correspondence via email, and/or phone calls in excess of 15 minutes. The Initial Evaluation is typically 1.5 hours in length ($285) given the time to review your records and background, review confidentiality and consent, discuss your current situation in detail, and establish goals for treatment. We accept a variety of payment options, including: Interac/debit, VISA, MasterCard, and cash payments. Cheques are currently not accepted. Upon payment prior to your session, a receipt will be provided to you for reimbursement/tax purposes.

Insurance

Psychologist's fees are not covered under the Nova Scotia's MSI Plan. Many private extended health care plans cover part, or a significant portion of psychological services. Please talk to your insurance provider directly to see what your specific plan covers. At this time we do **not** offer direct billing to insurance companies, therefore, regardless of third-party coverage we require payment in full prior to beginning each session.

Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families. Appointments cancelled with less than 24 hours notice by phone (902-444-1160) or email to your provider will be charged the full session rate of the time reserved for you unless a medical note is presented. Given emergencies/unforeseen circumstances do arise, **one** missed **or** cancelled appointment within 24hrs will **not** be charged to you. Following this, the charge will apply regardless of the reason for missing the appointment unless a medical note is presented or at least 24hrs notice is given. Whenever possible, please try to give at least one week's notice if you know you may not be able to make your appointment and we will be happy to provide you with another appointment time.

Confidentiality and Privacy

Please note that the use of our online practice management and scheduling software (Jane | janeapp.com) results in your treatment chart and Personally Identifiable Information/Protected Health Information (PII/PHI) being stored in secured Canadian based data storage servers.

All discussions with a psychologist are strictly confidential and your privacy is important to us. No information will be released to third parties without your explicit consent, except where required by law or in situations where the psychologist is ethically and legally required to disclose information to others without your consent. The following are examples of when your information may be released **without** written consent:

1. When an individual poses potential or **threatened harm to themselves OR to others** (in this circumstance the psychologist will act to protect the person(s) in danger by informing police, medical personnel, parents/caregivers, or other relevant individuals who may assist).
2. Suspicion of or risk of **child abuse** (psychologists are mandated reporters and required to report relevant information the Department of Children's Services).
3. Suspicion of **adult/elder abuse** (physical, sexual, and/or mental cruelty to anyone over 16 at risk of being abused due to physical or mental disability that impedes their ability to care for themselves).
4. In the event your information is **subpoenaed by a judge** or court of law in the case of legal proceedings
5. If services are **being paid by a third-party** (e.g., insurance), certain information may be disclosed (e.g. dates/time of service, who was present, fees charged).
6. Internal **consultation** amongst psychologists within Chorney & Associates Psychological Services.

Consent to Treatment

In order to voluntarily provide consent to treatment, an individual should understand **1)** the nature of the assessment and treatment, **2)** the potential benefits, risks, and side effects of treatment, and **3)** any reasonable alternatives to treatment (including refusal). It is important to note that consent is an ongoing process and you have the right at any time to ask questions about your treatment or terminate your treatment at this clinic.

> ***Adolescents.*** In the case the individual consenting to treatment is an adolescent, consent to treatment is obtained on a case-by-case basis and the consent/signature of a legal guardian or parent may be required depending on the ability of the adolescent to understand the points listed above. In most cases, privacy is protected to ensure the adolescent feels able to share confidential information (including drug use, lying, or sexual behavior) and this information will remain confidential unless a significant risk of harm to themselves or to others is revealed.

By signing below, I agree that I have read (or had read to me) and agree to all items with the Client Information & Consent form. I have discussed and asked questions about any portion of the form I find unclear or unacceptable, and have had my questions, if any, answered. I agree to act in accordance with the points and information listed above, and by signing I consent to taking part in both assessment and treatment with the provider named below.

_____ _____

(**Client** Signature) (**Client** Printed Name)

_____ _____

(**Clinician** Signature) (**Clinician** Printed Name)

_____

(**Date**)