Think Rational
Feel Positive &
Behave Constructive
DR. GHAZAL DAWOODI

Dr. Ghazal Dawoodi, Ph.D, RCC.
Seawall Medical Centre
#102 - 1590 Bellevue Ave.,
West Vancouver, BC V7V 3R5
Tel: (778) 238-4731
Fax: (604) 281-2404

ADULT CONSENT FORM

Confidentiality:
Your name and information about you and your counselling will be kept confidential, however, there are exceptions to this confidentiality, as follows:

a) If we believe that a child, elderly person, or disabled person is being abused.
b) If a patient threatens serious bodily harm to him or herself.
c) If a patient threatens serious bodily harm to another.
d) In some legal proceedings, upon a court order, testimony and/or records may be rendered.
e) If legal actions are brought against us by the patient and/or family, information may be disclosed if necessary and relevant to the case.

Psychological Assessment:
The assessments are not used to diagnose any mental disorder, but to see whether or not the client's answers on the assessment forms falls into clinical range, for further decision on treatment plan.

Working with Minors:
Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents or legal guardians to examine their clinical records.

Payment:
Fees are paid at the end of each treatment session by cash or MasterCard/visa card. Telephone consultations are prepaid or by arrangement. Individuals who have private extended medical coverage, which covers clinical counselling, usually submit their receipts to the private insurer for reimbursement. Fees are $120 per session for individual, couples and family counselling. Sliding scale for low income patients and students is $90 per session. Sessions are 50 minutes. Longer sessions may be available and will be prorated on the same hourly basis.

Cancellation:
24 hours notice is required for session cancelation. You may notify me of cancellation or rescheduling requests by telephone: 778 238 4731, or email: drghazaldawoodi@gmail.com. You will be billed for missed appointments if notice is not received. You may notify me of changes to scheduled appointments by voicemail or email. I have read and understand the statement made in these agreements and the attached Statement of Understanding.

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Name:_____
(Last) (First) (Middle Initial)

Address: _____
(Street Number, Street Name)

_____
(City) (Province/State) (Postal Code/Zip)

Phone Number: (_____)_____

Client Signature: _____ Date: _____

Counsellor Signature: _____ Date: _____