

## Client Consent Form

**By signing below, I understand/authorize/consent to the following:**

1. Arete counselling programs are designed as time-limited, goal-oriented mental health treatment programs using evidence-based modalities focused on solutions.
2. The collection and documentation of necessary information to manage my case file. Necessary information includes contact notes, dates of my sessions, summary of interventions, general assessment of my progress and counselling outcomes. This information is collected to ensure proper invoicing and therapeutic due diligence. This information is confidential and held only between the Arete Clinical Affiliate and Arete staff members. For quality assurance purposes Arete may review my file and confer with me or the Clinical Affiliate about my progress.
3. There will be no disclosure of any information to my employer or other third parties that would expose my identity or reveal the content of my counselling sessions, without my written permission.
4. The confidential nature of my counselling will be respected unless there is a reason to believe there is a risk to myself or someone else, including a child or if the file is subpoenaed by a court of law or duly authorized tribunal. Arete will only disclose the contents of my file in accordance with applicable law. In the case of counselling with family or other members, Arete cannot be responsible for a breach of one client's confidence by the other client.
5. Arete staff members managing my file will keep all personal information strictly confidential in compliance with applicable federal and provincial laws.
6. Anonymous information related to my treatment may be used for research purposes, regarding program effectiveness, satisfaction, improving services and demonstrating impact. I may be emailed a confidential survey pertaining the above-mentioned. Non-identifying demographic information and access information is collected and pooled for utilization reports to insurers.
7. Arete Clinical Affiliates must remain neutral. They are unable to make diagnoses or recommendations about legal, medical or work-related matters based on information gathered from Arete sessions. Arete Clinical Affiliates cannot participate in labour relations, disability assessments or act as an expert witness in court. Clinical Affiliates cannot write reports or letters for reasons not discussed in the initial request for counselling, which may place Arete in a conflict of interest with the employer.
8. Submitted reports to Arete represent a summary of the counselling sessions and are the confidential property of Arete. I may review this summary or obtain a copy upon request.
9. I may report a complaint with Arete or request a different Clinical Affiliate at any time. Arete may gather information to endeavour service provision is to my satisfaction.
10. This consent is valid for the time that Arete must maintain the file. If I meet with multiple providers, a new consent must be signed with each provider.

**Costs:** The cost of sessions is covered by my assistance program. I am responsible for the full cost of missed appointments and any appointments changed or cancelled with less than 24 hours notice, as may be assessed by the Clinical Affiliate. This pertains to counselling under any modality, face-to-face, telephone or video.



**File Closure:** Our counselling programs are designed as time-limited interventions rather than long term and open ended. Files can be closed if no appointments are booked within 60 days. Arete will endeavour to follow up with the Clinical Affiliate and client prior to file closure. Files can be re-opened if services are required later.

**Informed Consent:** Benefits, limitations and risks of counselling have been explained to me. I have read and understand the above and have discussed any questions with the Arete Clinical Affiliate. **(check box)**

_____	_____	_____
Client Name (please print)	Client Signature (or parent/guardian)	Date (DD-MM-YY)
_____	_____	_____
Client Name (if more than one client) (please print)	Client Signature (or parent/guardian)	Date (DD-MM-YY)

**Clinical Affiliate Name and Designation:** \_\_\_\_\_

**Confidential Client Code:** \_\_\_\_\_

*\*A photocopy of this document has the same validity as the original.*

Please email **BOTH PAGES** of the completed form to Arete at [clinical@aretehr.com](mailto:clinical@aretehr.com) or fax to 403-252-6161.