

**Kristy Carroll RMFT**  
**Individual, Relationship & Family Therapy**  
**(204) 299-2554**

**Confidentiality:** I (we) understand that the information I (we) provide will be kept in strict confidence by my (our) therapist. There are only two times when confidentiality will be broken, both of which are mandated by law. These are: 1) when sexual, physical, or emotional abuse of a child is disclosed, and 2) when the life of a client or any other person is in danger. The proper persons will be informed in both cases.

**Consultation:** I (we) understand that my (our) therapist will be consulting with clinical consultants on a regular basis; that the information I (we) provide about myself (ourselves) will be handled professionally and confidentially, and that these discussions will be for my (our) therapeutic benefit.

**Court appearances:** I (we) understand that my (our) therapist will not appear at, or participate in court proceedings. Therefore I (we) agree not to request this of my (our) therapist.

**Fees/Cancellations:** I (we) agree to pay \$ 95.00 per 50 minute therapy session. I (we) understand that I (we) will be charged the full fee for appointments missed or cancelled without 24 hours notice.

**Technology:** By checking this box, I (we) agree to be contacted through e-mail for the purpose of appointment scheduling and follow up. I (we) understand that my (our) therapist will not be immediately available via email and that in the case of emergency, the Klinik crisis lines are available anytime at 204-786-8686. I (we) also understand that for short notice cancellations, it is best to contact my (our) therapist directly by telephone.

**Agreement:** I (we) understand and agree with the policies as presented above.

**Client(s) Signature:**

**Date:**

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**Therapist Signature:**

**Date:**

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