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 $100.00 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 Klinic 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:**
____________________________	___________________