

Assigned Counsellor

Rate of pay

Date opened



Contact Information & Authorization for Emergency Medical

Client Name & DOB (current age)	
Parent or Guardian name	
Address	
Phone (s) Cell & Home (both client and guardian)	Permission given for messages Y/N
Email (s)	Client Parent or guardian Funder
Intake questions	<ol style="list-style-type: none">1. Have you been referred to a specific counsellor (by whom and which counsellor?) _____2. Would you prefer a male or female? _____3. What are the days and times you are available (pls note that not all times can be accommodated exactly) _____4. Would you be ok with a Master level intern? _____5. Do you need a reduced fee? _____6. Is the client connected to other supports and resources (pls name) _____ _____ _____7. Other _____ _____ _____ _____8. Name some of the challenges you currently struggle with (eg anxiety, depression, trauma, relationships, addictions) _____

<p>Funding Source</p>	<p>Funding main contact name _____</p> <p>Email _____</p> <p>Fee/hr _____</p> <p>Phone number _____</p> <p>Claim No. if CVAP: _____</p>
<p>Payment information</p>	<p>Credit Card number _____</p> <p>Name _____ exp _____ CCV code _____</p> <p>If paying by Credit Card: M/C / Visa / AM EX</p> <p>Private payments please circle preferred method: Cash Cheque Etransfer Credit card (2.9% + 0.30 \$ fee added)</p> <ul style="list-style-type: none"> • It is Clients responsibility to ensure funding is complete before start of sessions, clients must keep track of sessions remaining and end of funding period • For E-transfer use passcode "shamrock" • Credit Card# must be given before first session and will be charged for missed Intakes
<p>Administration notes:</p> <p>Date Open file _____</p> <p>Date Closed file _____</p> <p>Change of fees and date changed:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Other:</p>	

Emergency Medical:

	Name	Relationship	Phone
Emergency Contacts (2)			
Allergies & Medications			
Physicians Name & Phone			

In the event emergency medical aid/ treatment is required due to illness or injury during the process of attending workshops or individual sessions provided by Shamrock Wellness Services, I authorize the counsellors, facilitators, or volunteers to:

1. Secure and retain medical treatment and transportation if needed
2. Release records upon request to the authorized individuals or agency involved in the medical emergency treatment.

The authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed 'life saving' by the physician.

Client signature _____ Date_____

Parent or Guardian signature _____ Date_____