Dr. Kristina Towill & Dr. Ann-Louise Ellwood
Registered Psychologists

#306 - 3001 Tutt Street, Kelowna, BC V1Y 2H4
P (250) 763-3302, F (250) 763-3308

CONSENT TO TREATMENT

Client's Name: ______________________________________ M/F ________ Age: __ Birthdate: ______________
(mm/dd/yyyy)

Client's Address: ____________________________________ City: ____________________ Postal Code: _______

Mailing Address - if different from above: ____

Email: ____

Acceptable number to leave messages on? Home phone: **Y/N #**___________________________________

Work phone: **Y/N #**_____________________________ Cell phone: **Y/N #**________________________________

Appointment reminders - Circle one Preferred method only Home…………….Cell………………….Email
(Please note – ONLY your preferred method will be used for appointment reminders)

Employer: ____ Position/Title: _________________________________

Referred by: _______________________________________

Client's understanding of reason for referral (REQUIRED):

____

____

Date of 1st appointment: _______________________

I have read, or have had read to me, the "Information for Clients" brochure. I have discussed those points that I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in the brochure, and do seek and consent to take part in the treatment by the therapist named below.

____ Date: ____________________
(Client's Signature)

____
(Printed Name)

____ Date: ____________________
(Therapist's Signature)

Psychological Assessment, Counselling & Consultation