Mission Psychology Group

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

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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):

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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