ICTherapies
Susana Oppey, BABCP

Consent

Client Initials:	
D.O.B:	**Telephone No.**
GP Details: **GP Name:** **Practice address** **Telephone number**	**Address:** **Email:**

INFORMED CONSENT

Dear

You are due to start psychological treatment/assessment within Inspirational change Therapies Limited and there are some things for which we require your consent. Please could you complete the questions below.

***please amend as appropriate**

- Do you give your consent that we can contact your GP about your condition and treatment if we think it would be of benefit to your treatment? * **YES / NO**

If we are concerned for your safety or identify any risk to yourself or others at any time during your treatment, we may contact your GP or other relevant services as we would have a duty of care to do so. Where possible the reasons for this would be discussed with you but this may not always be possible.

We are required by law to keep records of the contact we have with you and the treatment provided. These records are stored on a computer database and kept confidentially for 7 years after your last contact. You have the right to withdraw this consent at any time by informing me directly in writing.

The data may be used for audits, but it is not possible to identify anything about you personally and would not be disclosed to any 3rd party not identified above without your written consent.

Do you understand and agree to the storage and limited usage of your data? ***YES / NO**

Cancellation policy – Please provide at least 48 hours' notice if you need to cancel an appointment, as late cancellations and non-attended sessions are chargeable or count towards your number of sessions.

Name: ……

Signed : ……..

Date: ……..