

Dr. Edward Anthony Allen, MB, BS, M Div,
DPM, MRC PSYCH, DM (PSYCH)
Consultant Psychiatrist
EL SHADDAI MEDICAL CENTRE
94¼ Old Hope Road, Kingston 5.
Telephone No. (876) 927-4824

INFORMED CONSENT

(NOTE: Clients must be adequately informed of their rights and responsibilities. I am, therefore, asking that you read the following carefully before signing).

I seek to provide services as specified on the brochure entitled "INFORMATION FOR PATIENTS".

ON YOUR PART

1. You undertake to pay at the end of each session, the fee per session. All cheques are made payable to **Dr. E. Anthony Allen**.
2. You undertake to pay **50 %** for all scheduled sessions **unless you cancel at least 24 hours before your scheduled appointment. Exceptions are made only in an emergency, at my discretion.**
3. **Except for when unavoidable circumstances necessitate these, repeat prescriptions will attract a fee of \$700.00**
4. If I counsel with your spouse or family member, **you are hereby agreeing not to subpoena me or any records relating to my counselling of your spouse or family member.**
5. If I provide therapy for your spouse or family member, should I (*Please initial the appropriate response*):

Check with you before sharing information or observations about you with your spouse or family member? _____

or

Use my own judgement in sharing information or observations about you with your spouse or family member? _____

or

Not disclose any observation except in your presence? _____

or

Consult with other professionals? _____

6. Please arrange to have a **thorough physical examination** within a few weeks of therapy, if you have not had one within the last 12 months. Kindly provide me with a report of the findings.
7. The initial stages or early sessions of therapy are sometimes difficult and uncomfortable for most people. If at any time during therapy, you develop negative or positive feelings towards me, please let me know, so that we can discuss them openly.

ON MY PART

1. **You have the right to confidentiality by Law.** Therefore I undertake not to reveal to any other person what you have said to me, without your written consent; except where:-

- (a) you have initiated a lawsuit against someone, and the court requires me to do so;
- (b) I am required so to do by law;
- (c) in my judgement, from information you have shared, I believe you are a danger to yourself or someone else (which may lead to a criminal offence). **I must notify the authorities and the person in danger. Failure to do so will make me liable for punitive action.**

2. Therapy will include a treatment plan and regular evaluation, which will be discussed with you periodically.

Please sign below indicating your acceptance of this Informed Consent. Please feel free to make any enquiries before signing.

Patient's Full Name

Name of Witness

Signature of Patient

Signature of Witness

Date

Date

CONSENT FOR SPIRITUAL CARE

1. I wish to include spiritual activities in my therapy: Yes () No ().
2. I will **share** and reflect about spiritual issues but **prefer not to engage in any formal spiritual activities in therapy** ().
3. I prefer to have **no special references to any religion** in my therapy ().

Signed: _____

Date: _____