

Date: \_\_\_\_\_

**Informed Consent for Yoga Fusion Psychotherapy  
Angela MacKay, M.Sc., Psychologist**

Client(s) Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone:(home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Email: \_\_\_\_\_

Current Occupation: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Referred by/learned of services from: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**I. Policy and Payment:**

I/We hereby acknowledge that the payment policy has been explained to me/us and I am in agreement with the following terms:

1) **The fee is \$190.00/60 minute session.** Requests for written reports and letters are subject to my hourly rate and will be billed accordingly.

2) **If I/we miss an appointment or do not give 24 hours notice of cancellation, I/we are aware that the credit card number provided will be charged in full for the full session fee. 24 hours notice will be given before the credit card is debited.**

3) There will be no billing of fees, rather, I/we will pay for each session with Visa/Debit/Mastercard, cash or cheque at the time of the service provided. **I understand that NSF cheques will then be charged to my credit card for the full session fee. 24 hours notice will be given before the session fee is charged to my credit card.**

**4) Credit Card Information:**

Credit Card Type: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Credit Card Expiry Date: \_\_\_\_\_ Credit Card Security #(3 or 4 digits) \_\_\_\_\_

Credit Card Billing Address (Postal Code): \_\_\_\_\_

## II. Confidentiality:

You have the right to confidentiality. However, the following are **legal exceptions** to your right:

**a) if you intend to harm yourself or another person, b) if you give me reason to believe that you are abusing/neglecting a child or a vulnerable adult, c) if my records are subpoenaed by a court of law.**

## III. My Training and My Approach to Psychotherapy:

I obtained my Masters of Science in Clinical Psychology from the University of Calgary in 2001. I am currently registered with the Nova Scotia Board of Examiners in Psychology and am a member of the Association of Psychologists of Nova Scotia.

The focus of my training was Cognitive Behavioural Therapy with children, adolescents, and adults. Through professional development, I have acquired knowledge and skills from other psychological perspectives, including Mindfulness Training, Phoenix Rising Yoga Therapy, Play Therapy, and Energy/Somatic Psychology. I am a certified Logosynthesis Practitioner, as well as a certified Phoenix Rising Yoga Therapy Practitioner.

My approach to counselling uses strategies from the above traditions which include: meditation and mindfulness practices, cognitive behavioural interventions, grounding exercises, art, play therapy, Qigong, Phoenix Rising Yoga Therapy, journaling, and Logosynthesis.

## V. What to Expect:

Yoga Fusion Psychotherapy is made of up of two elements: Mind/Body Psychotherapy and Phoenix Rising Yoga Therapy. During the initial assessment, a physical/mental health history is obtained and the different modalities used in Yoga Fusion Psychotherapy are explained in more detail. In subsequent sessions, you, as the client, choose whether you want a Phoenix Rising Yoga Therapy session or a Mind/Body Psychotherapy session, depending on your needs at the time. **Please wear comfortable, loose clothing and eat light before every session.**

**Phoenix Rising Yoga Therapy** sessions consisted of guided meditations, assisted yoga postures, and mindful dialogue that bring the client's awareness to their present moment experience. As this is a client centered modality, you are able to direct the session, letting me know how you feel about physical contact and touch, and which poses you would like to do. I will supporting your body throughout the session, while engaging in exploratory dialogue to bring your awareness to the present moment.

**Mind/Body Psychotherapy** is a holistic version of more traditional psychotherapy. Clients have the opportunity to discuss and explore feelings, learn new coping strategies, and problem-solve situations in a safe space that encourages mindfulness, creativity, and spirit.

It is helpful to be aware of your expectations of yourself and therapy, as having unrealistic

expectations can create more suffering and distress. Keep in mind that you may notice things getting worse before they get better. This is the nature of the therapeutic process and is nothing to be concerned about. Some of the above techniques will be introduced over the course of psychotherapy. I will explain their intended purpose, give instruction, explain their specific benefits and risks, and provide you with an opportunity to ask any questions.

**VI. Waiver:**

I, the undersigned, understand that Yoga Fusion Psychotherapy is not a substitute for medical attention, examination, diagnosis or treatment. I should consult a physician prior to beginning any physical activity, including Yoga Fusion Psychotherapy. I recognize that it is my responsibility to notify the practitioner of any serious illness or injury before every session. I accept that neither the practitioner, nor the hosting facility is liable for any injury, or damages, to person or property, resulting from the receiving a Yoga Fusion Psychotherapy session.

**I have read the above and understand that:**

- Sessions will be paid in full at the time of the session.**
- My credit card will be charged for the full session fee for late cancellations/missed appointments after receiving 24 hours notice.**
- NSF cheques will be discarded and the full amount of the session will be charged to my credit card after receiving 24 hours notice.**

I agree to the above terms for receiving psychological services.

Signature: \_\_\_\_\_

## Yoga Fusion Psychotherapy Intake Form

**Angela MacKay, M.Sc., Psychologist**

**Please complete all questions you feel comfortable answering.**

### Family Information

People Currently Living in Your Household

Name	Relationship	Age	Occupation or Grade Level

Please list the type and approximate date(s) of any other body work modalities you have received (i.e. massage, shiatsu, acupuncture):

Current exercise program:

Experience in yoga and/or meditation:

Briefly outline your personal support system (i.e., family, friends, health care providers, groups):

What do you hope to receive from Yoga Fusion Psychotherapy?

Describe your strengths, abilities, and coping strategies: \_\_\_\_\_

\_\_\_\_\_

Please list any history of surgeries, major illness, chronic conditions, accidents, injuries, including any pregnancy/birth complications: \_\_\_\_\_

\_\_\_\_\_

### Current Medications

(Please include prescriptions, over the counter, herbs, and supplements)

Medication	Dosage	Reason for Taking

### Past Medications

(Particularly those taken for Mental Health Concerns)

Medication	Dosage	Reason for Taking

Please list all of your past life stressors (death of friends/family, separation from parents, multiple moves/relocation), including when and what happened: \_\_\_\_\_

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Please list all of your current life stressors (up to one year ago): \_\_\_\_\_

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Has any member of your extended or immediate family ever been diagnosed, treated, or hospitalized for mental health concerns? \_\_\_\_\_

If yes, please list who, when, and for what reason: \_\_\_\_\_

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Do/did you have any family members who have/had problems with alcohol or using drugs?

\_\_\_\_\_ If yes, please list who, when, and if it is still a problem: \_\_\_\_\_

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Has any member of your family attempted or committed suicide? If so, please list who, when, and what happened: \_\_\_\_\_

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Please fill in the following section for any condition for which you have been treated in the past two years .

Health Care Provider	Dates of Treatment (approx.)	Condition
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Family Physician

Psychotherapist

Chiropractor

Psychiatrist

Homeopathic or  
Naturopathic Physician

Other (please list)

Please check any condition which applies to you:

Addiction Recovery: Length of time (days, months, years) in recovery:

AIDS

Arthritis

Asthma

Bulging or herniated disc

Chronic Fatigue Syndrome

Contact lenses (check only if you are wearing them now)

Degenerative disc disease

Depression

Eating disorder

Emphysema or other breathing problem

Fibromyalgia

Fatigue

Fused vertebrae

Heart condition

Hernia

High blood pressure: Do you take medication?

Hepatitis: Type

History of physical, sexual, and/or emotional abuse

Low blood pressure

Menopause

Multiple sclerosis

Osteoporosis

Pregnancy: How many months?

\_\_\_\_\_ Suicidal Thoughts/Attempts/Self-harm behaviours

Is there anything else you feel I need to know in order to work with you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_