Kali Hewitt-Blackie MA, RP
REGISTERED PSYCHOTHERAPIST #002467
OACCPP #0189-0178C
HST #763775715RT0001

6 Percy Street, Toronto ON M5A 3M8 | 416 992.2123 c | kalihewittb@gmail.com

WELCOME

Please read the enclosed PSYCHOTHERAPY AGREEMENT which includes:

CONFIDENTIALITY & PRIVACY

CONSENT TO RELEASE INFORMATION

As of April 2014, these forms are becoming mandatory for all psychotherapists in Ontario. They need to be provided to every client prior to beginning the process of psychotherapy.

Please read this document, sign it and send it to me prior to your first appointment. You can encrypt the completed form to send by email.

Warm regards,

Kali Hewitt-Blackie, RP, MA

Digitally signed by Kali Hewitt-Blackie, RP, MA
Date: 2025.12.27 17:01:57 -05'00'

Kali Hewitt-Blackie, MA, RP, OVCS, CMHP
Registered Psychotherapist #002467
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PSYCHOTHERAPY AGREEMENT

Psychotherapy occurs within a confidential relationship between a client and a therapist. As with all relationships, there are expectations. You may be reading this Agreement after some of the steps described below have already occurred.

PROCESSES, PAPERWORK & APPOINTMENTS

ALL new clients (from January 1, 2014), will be asked to complete an Intake (Personal History) Form and this Agreement prior to their first session.

A free telephone consult (15 min) with Kali Hewitt-Blackie is provided, prior to booking the first session. This can help determine whether I am a therapeutic fit for your needs.

INSURANCE COVERAGE

Sessions are booked at the client's request and may be cancelled without charge up to 24 hours prior.

- A cancellation fee applies which is full payment for time-booked.
- The length of your sessions are 50 minutes, until otherwise negotiated, in advance.
- The fee for the session is based on my hourly rate, unless a reduction has been negotiated.
- Appointments starting late due to client arriving late nevertheless end at the scheduled time.
- Appointments started late due to the therapist running late will either be extended or pro-rated.

Psychotherapy services are not covered by OHIP, but are often partially or fully covered by employee benefit or other private health insurance plans. Before the first session, the client is advised to check their benefit or insurance plan to ensure compliance with its coverage and claim procedures (eg, whether or not a referral from your physician is required).

FEES & PAYMENTS

- Initial phone consultation: no charge. Please note this is a 15 minute Q&A telephone call, not a therapy session.
- Individual Psychotherapy regular rate: $230/50 minute session
- Couples/Family Psychotherapy regular rate: $260/50 minute session
- Zoom Psychotherapy is available
- Text messages and emails related to appointment times and scheduling are handled without charge.

Preparation of letters or documents will be charged *pro rata* at the therapist's regular session rate. Therapist attendance outside of regular office appointments required due to emergency or other necessity of the client will be charged at the therapist's regular hourly rate. These payments are due within 5 days of the service being rendered or as negotiated with the Therapist.

IN CASE OF EMERGENCY

Kali Hewitt-Blackie, does not provide emergency health services. In the case of emergency, the client should dial 911, contact their family practitioner, or go to the emergency department of any hospital.

PERSONAL PROPERTY

Kali Hewitt-Blackie is not responsible for the personal property of clients inadvertently left behind at my office. While every effort will be made to put lost and found items aside for a reasonable period of time, the safe-keeping of such items cannot be guaranteed. It is the responsibility of clients to claim such items promptly.

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PERSONAL RESPONSIBILITY

The client acknowledges that responsibility for personal actions is not altered by virtue of receiving therapeutic services. The client agrees to hold the therapist free of all liability and responsibility for any actions or results or adverse situations created as a direct or indirect result of actions taken by the client during or after the termination of therapy.

CONSENT TO RECEIVE PSYCHOTHERAPY

By signing below, I acknowledge that I have read and understood the above information, and give permission and consent to Kali Hewitt-Blackie, to provide psychotherapy consultation, assessment and/or treatment to me/us and/or my child, _____, and that the terms of agreement outlined in this document are understood and agreed upon by all parties according to the terms and conditions outlined in this document.
I also agree to pay all fees outlined by this agreement associated with the psychotherapy services provided by Kali Hewitt-Blackie.

TERMINATION

This Agreement may be terminated at any time by the client. Subject to the Code of Conduct of the College of Registered Psychotherapists of Ontario, this agreement may be terminated by Kali Hewitt-Blackie. If you have any questions or concerns about my policies, kindly ask me.

AGREED UPON FEE $ / 50 minute session

_____ _____
PRINT: CLIENT SIGNATURE: CLIENT

_____ _____
PRINT: CLIENT/PARENT/GUARDIAN IF UNDER 18 SIGNATURE: CLIENT/PARENT/GUARDIAN IF UNDER 18

_____ _____

Kali Hewitt-Blackie, RP, MA
Digitally signed by Kali Hewitt-Blackie, RP, MA
Date: 2025.12.27 17:02:24 -05'00'

Kali Hewitt-Blackie, MA, RP,OVCS, CMHP
REGISTERED PSYCHOTHERAPIST SIGNATURE

DATED this _____ day of _____, 20_____.

CANCELLATION POLICY

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness. Unfortunately, there are no exceptions to this policy. Thank you for your understanding.

_____ _____
PRINT: CLIENT SIGNATURE: CLIENT

_____ _____
PRINT: CLIENT/PARENT/GUARDIAN IF UNDER 18 SIGNATURE: CLIENT/PARENT/GUARDIAN IF UNDER 18

_____ _____

Kali Hewitt-Blackie, RP, MA
Digitally signed by Kali Hewitt-Blackie, RP, MA
Date: 2025.12.27 17:02:36 -05'00'

Kali Hewitt-Blackie, MA, RP,OVCS, CMHP
REGISTERED PSYCHOTHERAPIST SIGNATURE

DATED this _____ day of _____, 20_____.

Kali Hewitt-Blackie MA, RP
REGISTERED PSYCHOTHERAPIST #002467
OACCPP #0189-0178C
HST #763775715RT0001

CONSENT TO RELEASE INFORMATION

Complete only in case you would like me to coordinate our work with another provider (for example, your primary care physician, other healthcare professional) or you want me to discuss your progress with a family member, etc, please provide me with the following consent:

I _____

(Name, please print)

Of

_____

(Location and address, please print)

give my consent to:

Kali Hewitt-Blackie

Kali Hewitt-Blackie, MA, RP (Registered Psychotherapist)

to speak on my behalf to:

_____

(Name and designation of individual; name of facility or agency)

_____

Address

_____

Telephone & Email Address

_____

to consult, request, release and/or share the following information:

_____

for the time period between _____20_____ and _____20____.

I understand I can verbally withdraw this authorization at any time prior to the expiration date. I also understand that any consultation will be focused on assessing my needs or those of my dependent and assisting in commencement, coordination and follow-up of any psychotherapy plan that may be formulated. I also understand that any discussion or documentation exchanged will be held in confidence by both parties.

_____ _____

PRINT: CLIENT SIGNATURE: CLIENT

_____ _____

PRINT: CLIENT/PARENT/GUARDIAN IF UNDER 18 SIGNATURE: CLIENT/PARENT/GUARDIAN IF UNDER 18

_____ _____

Kali Hewitt-Blackie, RP, MA

Digitally signed by Kali Hewitt-Blackie, RP, MA
Date: 2025.12.27 17:02:48 -05'00'

Kali Hewitt-Blackie, MA, RP,OVCS,CMHP
REGISTERED PSYCHOTHERAPIST SIGNATURE

DATED this _____ day of _____, 20_____.

Kali Hewitt-Blackie MA, RP
REGISTERED PSYCHOTHERAPIST #002467
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CONFIDENTIALITY & PRIVACY POLICY

It is important that you understand the confidential nature of your relationship with your psychotherapist, Kali Hewitt-Blackie.

I respect and protect the personal information of my clients and am compliant with all Provincial and Federal privacy requirements, including Personal Health Information Protection Act (PHIPA). Although personal information disclosed to me is confidential, there are certain exceptions/circumstances in which confidentiality cannot be maintained.

I am required to disclose confidential information if any of the following conditions exist:

LIMITS TO CONFIDENTIALITY STATEMENT

I. If a child has been abused or is being abused, the therapist is required to report this to the Children's Aid Society.

II. If another health care provider has sexually abused the client, the therapist must report it to the appropriate regulatory college.

III. If a client reports that they are planning to harm themselves or someone else, the therapist has to intervene to ensure that the client and/or other individual are safe.

IV. If for some reason a client is involved in a court case, your client record may be subpoenaed. I will attempt to keep these records confidential, but sometimes it may not be possible to do this.

V. In addition, I may be required to provide access to my information to auditors representing the College of Registered Psychotherapists of Ontario. According to the requirements of the college, my clinical file will be kept in a secure location for a minimum of 10 years, after the last date of contact, or 10 years after the youngest child's eighteenth birthday.

I/we have read, understood and agreed to the above Limits to Confidentiality, and I/we am/are consenting to receive services on this basis.

PRINT: CLIENT

SIGNATURE: CLIENT

PRINT: CLIENT/PARENT/GUARDIAN IF UNDER 18

SIGNATURE: CLIENT/PARENT/GUARDIAN IF UNDER 18

Kali Hewitt-Blackie, RP, MA

Digitally signed by Kali Hewitt-Blackie, RP, MA
Date: 2025.12.27 17:03:07 -05'00'

Kali Hewitt-Blackie, MA, RP,OVCS,CMHP
REGISTERED PSYCHOTHERAPIST SIGNATURE

DATED at Toronto, this _____ day of _____, 20_____.