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Consent Form

I agree to engage in clinical psychology services with Equilibrium Bermuda. I understand that this is a voluntary service and that I may withdraw my consent for treatment at any time.

I understand that as part of the provision of clinical psychology services the therapist will need to collect and record personal information that is relevant to my current situation. This information is a necessary part of the clinical assessment and treatment process.

I understand that all personal information gathered during the provision of clinical psychology services will remain confidential and secure. I understand that very rarely, confidentiality may need to be broken:

a) if I inform my therapist of any intention to harm myself the therapist is legally obligated to access help to prevent this harm;
b) if I inform my therapist of intent to harm another person who is identifiable, the therapist is legally obligated to inform the local authorities and the identified person;
c) if I inform my therapist of a vulnerable person i.e. senior, child or person with a learning disability, who is being abused in any way, the therapist is obligated to inform the local authorities.

I understand that this will be done for the purpose of accessing extra support for me and my therapist will make every attempt to discuss this with me prior to doing so.

By signing this document I understand that any grievances or complaints regarding my treatment at Equilibrium Bermuda may be presented in writing to the Chairperson of the Bermuda Psychologist Registration Council, P.O. Box 56, Paget PGBX (email: bdapsychcouncil@gov.bm).

_____	_____	_____
Print Name of Client	Signature of Client	Date
_____	_____	_____
Print Name of Power of Attorney (if applicable)	Signature of Power of Attorney (if applicable)	Date