



THERAPY CONSULTATION BOOKING & CONSENT FORM (PAKISTAN)

Client Information

- Full Name: _____
- CNIC / B-Form (optional): _____
- Date of Birth: ____ / ____ / ____
- Gender (optional): _____
- City & Country: _____
- Contact Number (WhatsApp): _____
- Email Address: _____

Emergency Contact (Mandatory for Online Therapy)

- Name: _____
- Relationship: _____
- Contact Number: _____

In case of emergency or safety concerns, this person may be contacted.

Consultation Details

- Type of Session: Initial Follow-up
- Mode: Online (Zoom / Google Meet / WhatsApp Video)

In-person

- Preferred Date: ____ / ____ / ____
- Preferred Time: _____
- Session Duration: _____ minutes

Fee & Payment Policy

- Consultation Fee (PKR): _____
- Payment Method: Bank Transfer JazzCash Payoneer
- Payment Timing: Advance Only

Sessions are confirmed only after advance payment. Payment details will be shared upon booking.

Cancellation & No-Show Policy

- Cancellations must be made at least 24 hours in advance.
- Late cancellations or failure to attend the session will be charged in full.
- Rescheduling is subject to therapist availability.

Online Therapy Disclaimer

- Online therapy may be affected by **internet connectivity, technical issues, or privacy limitations.**
- The client is responsible for ensuring a **private, quiet, and safe environment** during the session.
- Sessions will not be recorded without written consent.

Confidentiality & Legal Limits

All information shared during therapy is **strictly confidential** in accordance with professional ethical standards practiced in Pakistan.

Confidentiality may be breached **without consent** only if:

- There is a **serious risk of harm** to the client or others
- **Child abuse, neglect, or exploitation** is disclosed
- Required by **Pakistani law or court order**

Scope & Nature of Psychological Services

- Therapy is a **professional psychological service**, not a guarantee of outcomes.
- Therapy **does not replace psychiatric, medical, or emergency care.**
- The therapist may recommend **psychiatric referral or in-person services** if clinically required.

Consent for Online Psychological Services

I confirm that:

- I am **18 years or older**, or consent is provided by a legal guardian.
- I understand the **nature, benefits, and limitations** of online therapy.
- I agree to the **fees, policies, and confidentiality terms** stated above.
- I voluntarily consent to receive online psychological consultation.

Client Declaration

- Client Name: _____
- Signature (Typed / Digital): _____
- Date: ____ / ____ / ____

Therapist Details

- Therapist Name: _____
- Qualification: _____
- Specialization: _____
- Contact Email / WhatsApp: _____
- Therapist Signature: _____
- Date: ___ / ___ / ___

Important Note

This online consultation is for psychological guidance and support.

It is not an emergency service.

In case of immediate danger, contact local emergency services or visit the nearest hospital.