THERAPY & CO.

INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Personal Health Information Protection Act (PHIPA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

CONSULTATION AND PSYCHOTHERAPY CONSENT FORM

I have read and/or have had explained or presented to me the following information relating to myself or my minor child(ren)consultation and treatment. By signing below, I am indicating that consent to this consultation and/or treatment.

CONFIDENTIALITY

I understand that the matters discussed in therapy are personal and will be kept within the strictest confidence. I understand that information obtained will only be shared with my written consent.

I have also been advised that all regulated health providers are subject to the rule that this assurance of confidentiality is waived in the following rare situations:

- When there is suspicion of child abuse
- When clients pose a significant danger to themselves or other
- When clients report sexual abuse by health care professional
- If there is a true inability to care for oneself
- or if the court issues a subpoena for records. In all these situations, the written records will not be released without the opportunity for myself to review them.

I understand that communication/information sent and/or received by email; text or online cannot be guaranteed to be confidential.

RECORD KEEPING

I understand that paper and electronic records of counseling sessions are kept. These records are brief notes from sessions or, on occasion, from between-session contact. They will not be

shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should I wish to have my records released, I will be required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked compartment.

CANCELLATION & RESCHEDULING

I understand that the appointment times I am given have been reserved for me, and I will make every effort to attend punctuality. I realize that, in order not to be charged the full fee for a cancelled or rescheduled appointment I am required to call 24 hours in advance of my appointment time and date, and that, if my appointment is scheduled to a Monday, Saturday or Sunday, it must be cancelled by end of working day on the preceding Friday. I understand that cancellation of an appointment must be done by telephone and that I may leave a voice or text message if I am unable to speak directly with my therapist.

FEE AGREEMENTS

I understand I am responsible for paying for sessions at the time of the session unless prior arrangements have been made. Payment may be made by certified cheque, cash or E-Transfer using the following email address: anitaowusutherapy@gmail.com. A regular fee will be charged in 15-minute increments for additional services rendered at my request outside the therapy, including phone call, text conversations, preparations of special forms and letters, insurance reports, court or appearances. I am aware that when a session is held for a minor with parent/caregiver, payment will be collected directly for the individual for who the service was provided.

INSURANCE

I understand that insurance for payment is not accepted however a receipt for therapy services will be provided. I may submit the receipt to receive some measure of reimbursement should my policy reimburse for out-of-network providers.

CONTACTING ME

I understand Anita Owusu is not immediately available by telephone, but I am welcome to leave a voicemail at (905-459-3526), which is checked throughout the day and less frequently over weekends and holidays. Attempts are made to respond to all callers within 24 hours, however, on occasion, it may take up to two days if it is not an urgent matter. If I feel I cannot wait for a return call or it is an emergency situation, please go to your local hospital or call 911. I can also contact Toronto Distress Crisis Centre.

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VIRTUAL SESSIONS & INSTRUCTIONS

Virtual Care is offered online to provide face to face sessions over a computer/tablet. Due to the nature of virtual care there is an inherent risk to the service being secure and confidential. As there is no Internet platform that is 100% secure and confidential, every precaution to ensure your confidentiality is maintained and unnecessary disclosure from occurring.

- I understand that a free online platform for private meetings is used (and falls within the limits of virtual care noted above).
- An email link and invitation to the day of the appointment and no later than 30 mins prior to session.

VIDEOTAPING

All consultation and treatment sessions may be videotaped. They will be used for one or more of the following purposes (the first one is the only one that is absolutely required; cross off and initial the ones that you do not agree to):

- Treatment planning with professional colleagues.
- Use of written transcript and descriptions for written publications and scientific meetings (all identifying information is changed or deleted).
- The use of transcripts and/or videotapes for psychotherapy research, with only the researchers having access to the materials.
- Teaching of health professionals using videotape vignettes.

I have read the above information and agree to abide by the terms laid out in this communication agreement.

_____

Print Name

_____ _____

Signature Date