

GUELPH PSYCHOLOGISTS

Terms of Service

NOTE TO CLIENT: We would like your informed consent for the services we are to provide. This means that we want you to understand the services we hope to provide you, the cost involved, and what we do with the personal information we obtain about you. If you have any questions about any of this information, please ask.

CONFIDENTIALITY

I understand that all of our conversations are confidential and private and cannot be shared with any other individual (e.g., family members, employers, health professionals) without my informed and voluntary consent. I understand that a record of our meetings and conversations will be kept in a secure cabinet. There are six exceptions to this rule of confidentiality. These are:

1. *When* you provide me with written permission to have information from your therapy sessions disclosed to another person(s) (e.g., physician, another therapist, community agency). In this case you will be requested to sign an authorization for the release of information.
2. *When* you disclose to me or it becomes evident that you are at risk of injuring yourself or others (e.g., suicide, assault, homicide). In this situation we need to access other resources as a means of helping to ensure your safety and the safety of others.
3. *When* you disclose that a child has been or is at risk of being physically, sexually or emotionally abused or neglected or, has been a witness to violence in the home. Ontario Provincial law requires that I make a report to Child and Family Services when I become aware that a child is at risk and in need of protection according to the Child Protection Act.
4. *When* you disclose that you have been sexually abused or harassed by a regulated health professional under the Health Professional Act (e.g.: doctor, social worker, etc.).
5. *When* I am mandated (subpoenaed) by a court to disclose information in a legal proceeding.
6. *When* your treatment is covered by a third party (e.g., WSIB, automobile insurance), part or all of your personal health record may be requested.
7. *When* you Report Abuse or Neglect of residents living in Long-Term Care Facilities or Retirement Homes.

CONSENT FOR COST OF SERVICES

I understand the cost for treatment and I am aware that I will be billed for treatment sessions that are missed without at least **24-hour cancellation notice**, (ie Monday appointments need to be cancelled on Friday). Should I need to cancel due to illness or an emergency, a charge will not apply. Fees are payable at the conclusion of each session. If the treatment is being covered under a WSIB or automobile insurance claim, the third party will be billed directly for the treatment provided.

APPOINTMENTS

I am aware that if I am late for an appointment, it is usually not possible to extend the original appointment time. Appointments are the 50 minute "therapy hour". The therapist uses the remaining 10 minutes of the hour to make notes of the session.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with psychological services the psychologist I see will collect some personal information about me (e.g., home telephone number, address, treatment history, symptoms).

I have reviewed the Privacy Statement of Guelph Psychologists about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Statement applies to me.

I understand that, as explained in the Privacy Statement, there are some rare exceptions to these commitments.

I agree to Guelph Psychologists collecting, using and disclosing personal information about me as set out above in the Terms of Service and in the Privacy Statement of Guelph Psychologists..

GUELPH PSYCHOLOGISTS TERMS OF SERVICE

In signing below, I am indicating that I was given and that I understood the information concerning the terms of service for treatment and/or assessment procedures outlined above including cost of services, the limits to confidentiality, the collection of personal information and the privacy statement. I have had the opportunity to ask questions, and to have my questions answered appropriately and to my satisfaction. I consent to treatment and/or assessment with the understanding that I may terminate these services at any time.

Client Signature

Therapist Signature

Client Name (Printed)

Date