

CONSENT FOR TREATMENT

I, the Client, hereby consent to receiving psychological treatment with the following understandings:

Limits of Confidentiality

I understand that all information shared with my therapist is confidential and no information will be released without my written authorization. I understand that any personal information that is collected is done so under the Health Professions Act (HPA), the Personal Information Protection Act (PIPA) and where applicable, also the Freedom of Information and Privacy Act (FOIP), and is gathered by Insight Psychological Inc. (Insight) solely for the purposes of collecting fees, mailing forms, arranging appointments, facilitating my treatment, and managing my treatment records. My personal information will not be used for any purpose other than those outlined in this *Consent for Treatment* nor be released without my consent except as required and permitted by law. Verbal consent for limited release of information may be necessary in special circumstances which will be discussed and attained prior to any action taken with my personal information. I further understand that there are specific exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, my therapist is ethically and legally bound to take necessary steps to prevent such danger. This may include contacting relevant authorities even if I do not wish my therapist to do so.
- B. When there is a reasonable suspicion that a child, elder, or any vulnerable person is being sexually, physically or emotionally/psychologically abused, neglected, or is at risk of such abuse, my therapist is legally required to take steps to protect the person and to inform the proper authorities.
- C. When a client reports a psychological condition, that in whole or in part, was caused by something that happened at work and psychological symptoms have caused them to be off work for more than one day, and/or caused or is likely to cause them to be unable to perform their regular working duties, the therapist is legally bound to file a WCB report.
- D. All other requests for my personal information to be either released or obtained by my therapist or other professionals (e.g., my family physician, lawyers, etc.) will be discussed as they arise and will require my written permission to comply, unless ordered by court.
- E. In case I have elected to see my therapist out of multiple offices, I understand that this requires the physical transfer of my file, which may jeopardize my confidentiality (i.e. in the case of a vehicle collision or theft).
- F. That non face-to face-work (i.e. phone, video counselling, etc.) has certain confidentiality risks associated with it as Insight cannot control the client's technology access, security provisions, or privacy limitations.

Risks and Benefits of Psychotherapy

I understand that while psychotherapy may provide significant benefits based on empirical evidence, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recollection of troubling memories. I also understand that choosing not to engage in therapeutic treatment may also result in greater discomfort or escalating risks. I also acknowledge that I have been informed here that my feedback and communication about the therapy process and impact is crucial in reducing my risk for harm, and that I am encouraged to communicate any concerns or discomforts with my therapist as soon as possible in my treatment. I also acknowledge that therapy is most effective when I am comfortable with my therapist and so, should I not feel comfortable or connected to this therapist I will either request a transfer to another individual or make my concerns known in order to best facilitate care for myself.

Client's Rights and Responsibilities in Therapy

I understand that I have a right to ask questions at any time as well as be informed by my therapist of their qualifications, areas of specializations and limitations, and the code of ethics which they follow. I have a right to consult with my therapists on the appropriate type of evidence-based treatment I may receive, be advised as to the limits of therapeutic service, and discuss my treatment with others (including getting a second opinion). I also have a right, should I see fit, to request for a change in therapist or approach, or be referred to another professional to ensure that I receive the best care possible.

I understand that I may stop treatment at any time and that this consent will remain in effect until such a time as I withdraw it via written consent or discontinue services with my therapist by informing them of my intent to do so. I understand that I have a right to view my file notes at any time and to know what is being recorded about me. I understand that I am responsible for setting therapeutic goals for my treatment and review them as required. I will cooperate with my therapist in evaluating the treatment process and work toward achieving my self-identified goals. I understand and accept that I am responsible for the decision on how to handle issues identified in my interactions with my therapist as well as for implementing or integrating strategies, choices, actions and results arising out of or resulting from my interactions with my therapist. I further understand that my non-engagement in therapy or in therapeutic exercises, as introduced or recommended by my therapist, may delay or inhibit the achievement of my therapeutic goals.

I also acknowledge that I have been informed here that if my therapist is a Registered Provisional Psychologist it means they have not fully completed licensure requirements through the College of Alberta Psychologists and is thus required to obtain supervision at least 1 hour per month with a Registered Psychologist. I further understand that my file information can be shared with their supervisor for the purpose of due diligence and consultation, but that my information will not be released outside of these individuals without my/our written consent.

I understand that should I have a concern with my service or therapist, I can contact Insight's Clinical Director at 780-461-1717. If a specific ethical or practice breach, in accordance with College of Alberta Psychologists' Code of Conduct is unaddressed, I may bring the matter to the College of Alberta Psychologists.

Participation in Online and/or Telephone Therapy Sessions

I understand that I have the option to participate in online and/or telephone therapy with my therapist, when and where appropriate to do so. Should I choose to participate in online or telephone therapy sessions, I will do so with following understandings:

Online Information Collection and Usage, Service Limitations and Service Options

I understand and accept the following:

- Insight uses the OnCall and Jane platforms to facilitate secured online therapy sessions.
- For online therapy sessions, my personal information is gathered in coordination with OnCall or Jane solely for the purposes specified in this consent. My personal information will not be used for any purpose other than those outlined in this *Consent for Treatment* nor be released without my consent except as required and permitted by law.
- I will read and agree to the terms and conditions specified in OnCall's or Jane's Privacy and Usage Policy prior to proceeding with my online sessions.
- Online and phone therapy sessions are not intended to replace the more optimal in-person sessions, but they are utilized upon my request, when in-person sessions are not convenient or possible.
- There is a potential for misunderstandings when visual cues are absent and/or limited in online communications. As such, either my therapist or I may need to seek clarification when ambiguities or questions of misinterpretations surface.
- Certain therapeutic interventions may not be available through online or telephone means or may have to be modified in order for it to work online or over the phone.
- In order to provide me with the best possible service, my therapist and I will need to routinely review the appropriateness of continuing my therapy online or over the phone, taking my best interest into consideration. My therapist or I reserve the right to discontinue my therapy online or over the phone and transfer me to in-person or other means of service should they or I conclude that I would receive greater benefit from in-person services or other means of service. As well, my therapist will, in consultation with me, make a referral for me to another source of mental health care if my therapist is unable to provide adequate or needed services to me.
- In the event of an emergency, I can call 911, go to the nearest hospital, or call the Distress Line at 780-482-4357.

Technology Limitations

While Insight will make every reasonable effort to implement technical security measures to reduce the risk of a confidentiality breach on its end, I recognize and accept the risk that no internet-based communication can be guaranteed to be 100% secure or confidential, and that risks such as internet participation being discovered by others and the possibility of hackers may still occur. I accept that I may be required to provide proof of my identity or other identifiers in order for Insight to ensure that my information and service sessions are adequately protected. I also understand and accept that technical difficulties or complications may occur at any stage and part of my online therapy sessions. Such may include but not limited to login difficulties, time delays/lags, equipment failure, slow internet speed, and others. In the event that any of my online therapy session is disrupted, my therapist will attempt to re-establish our online connection. Should the technical difficulties persist, making it not possible or feasible to continue our online session, my therapist will make efforts to continue our session through other means such as over the telephone or they may have Insight reschedule another online or phone session for me.

Client Responsibilities for Online Sessions

In order to minimize difficulties or interruptions with my online therapy sessions, I will:

- use high-speed password protected Internet connection or secured, encrypted wi-fi connection. I will download and use Google Chrome web browser when and where needed to facilitate my online therapy sessions.
- Use a computer or laptop on which appropriate antivirus/firewall and security software (e.g. paid versions of Bitdefender, McAfee, Norton, Kaspersky, etc.) has been installed and activated,
- ensure that the audio, mic, and visual tools on my computer or laptop are fully functioning,
- plan ahead to minimize distractions (e.g. use a quiet room that I can be uninterrupted, not answering calls or text while in session, use headphones to increase privacy if necessary),
- log-on five minutes early to ensure that the online platform is functioning and that I am able to complete any pre-session activities such as downloading the platform, read instructions or consent, fill our necessary information, etc.,
- close other programs on my computer prior to the start of my session,
- NOT have any additional individual(s) other than myself be present in my online therapy sessions without prior approval from my therapist. Should their presence be allowed, I will ensure that they read, understand, and agree to the terms and conditions in this Consent for Treatment, and

- NOT record (audio, video, or any other form) or share any portion of my online therapy session(s) with any party without prior written approval from Insight Psychological Inc.

Attendance and Cancellation

Individual therapy sessions are between 50 and 55 minutes in duration. Session frequency can vary over the treatment period, depending on the specific therapy goal and the progression of treatment. I agree to inform Insight at least 24 hours prior to our appointment time if I need to cancel or change an appointment time. I understand that **unexcused no shows or cancellations with less than 24-hour notice will be automatically billed/charged at 50% of the total cost of the session booked.**

Financial Agreement

I understand and accept that my session fee is \$200 per hour, unless stated otherwise, for a face-to-face, online, and telephone therapy/consultation session. Such a session entails 50 to 55 minutes of meeting time and 5 to 10 minutes of report writing time and this excludes initial telephone, in-take, or scheduling time). I also understand and accept that other billable services, such as report writing, professional letters, form completion, and review of written records from other specialists are billed at the same rate unless made known to me otherwise. I understand that a retainer amount may be collected to hold an appointment or prepare for an assessment and that additional charges will be added to that retainer to reach previously discussed or agreed upon fee for service and fees shall not exceed the agreed upon amount.

For in-person therapy sessions (except for sessions at Insight’s Spruce Grove service centre), I agree to pay promptly at the time of check-in for each session, all fees and charges owed to Insight Psychological, except for the amounts that can be immediately received or that have already been approved for payment by a third party through instant direct billing by Insight Psychological or through a pre-established contractual agreement. Insight Psychological accepts VISA, MASTERCARD, DEBIT, E-TRANSFER, and CASH for the in-person therapy sessions to be rendered. I give my consent to Insight Psychological to charge my credit card on file and/or to access other agreed upon means of payment, for the fees and charges owed to Insight Psychological.

For online or telephone therapy sessions as well as for in-person therapy sessions at Insight’s Spruce Grove location, I agree to pay 48 hours prior to each session, all fees and charges owed to Insight Psychological, except for the amounts that can be immediately received or that have already been approved for payment by a third party through instant direct billing by Insight Psychological or through a pre-established contractual agreement. I understand that I am responsible for contacting my insurance carrier to find out if they would cover online or phone therapy sessions. Insight Psychological accepts VISA, MASTERCARD, and E-TRANSFER for therapy sessions to be rendered online, via telephone, and in-person at its Spruce Grove location. I give my consent to Insight Psychological to charge my credit card on file and/or to access other agreed upon means of payment, for the fees and charges owed to Insight Psychological. Should my payment be rejected/declined at the time of processing, Insight will contact me by phone, text, and/or by e-mail to notify me of this payment failure and to provide me with an opportunity to rectify the matter. I understand and fully accept that should Insight not receive full payment from me at least 24 hours prior to my online, telephone or Spruce Grove location therapy session, my session will be automatically cancelled and Insight will send me an e-mail notice of cancellation.

Service fees are tax deductible and I will receive a receipt upon payment. I understand that should I be unable to remit full payment for any outstanding fees and charges owed, I will not be able to book and access any further services at/from Insight Psychological until such a time as I have paid my outstanding fees and charges in full. I hereby also agree to pay all fees, charges and legal costs incurred for services associated with the recovery of outstanding amounts owed.

Consent acknowledgement by the Client who is proceeding with online or phone therapy without an in-person check-in prior to their first online or phone therapy session:

By choosing to proceed with my online and/or phone therapy session, I acknowledge that I have read, understand, and agree to all the terms and conditions specified in this *Consent for Treatment*.

Consent acknowledgement by the Client who is checking-in in-person prior to their first therapy session:

With my signature below, I acknowledge that I have read, understand, and agree to all the terms and conditions specified in this *Consent for Treatment*.

Client’s Name (print): _____

Witness (print): _____

Signature: _____

Signature: _____

Date: _____

Date: _____

E-mail: _____

Phone Number: _____