Embrace the path to freedom

Please return this form to Innerwaves Counselling by either mail or email or through Doxy.me platform at the first session.

Teletherapy (phone or video) Informed Consent Form

I hereby consent to engaging in teletherapy with my existing therapist at Innerwaves Counselling. I understand that "teletherapy" includes the practice of mental health care delivery, consultation, transfer of relevant data, and education using interactive audio (phone) or video communication devices.

I understand that teletherapy involves the communication of my personal, counselling session information via the teletherapy service, doxy.me, which is a HIPAA and PIPEDA compliant video platform service. This platform that has been chosen by Innerwaves Counselling uses high quality industry standard privacy and security measures. For additional information regarding their privacy standards and tips of privacy, you may visit their website: www.doxy.me.

Teletherapy is a temporary service that is being offered to all Innerwaves' clients as a precautionary measure due to extreme circumstances regarding the Covid-19 pandemic. Once these circumstances abate, therapy sessions will return to in-person services. Please contact your therapist directly if you have any questions.

I understand that I have the following rights and responsibilities with respect to teletherapy:

I have the right to withhold or withdraw consent at any time, without affecting my right to future therapy, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
The laws and standards that protect the confidentiality of my mental health therapy information also apply to teletherapy. To summarize, there are mandatory exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim, including myself; and if information from my file is subpoenaed by a court of law.
I also understand that my express consent is required to forward any personal information to a third party (such as a doctor, etc.)

I understand that my therapist will be providing teletherapy services from either the offices of Innerwaves Counselling 619-3rd Ave.N. Saskatoon, OR from the home office of my therapist.

I further understand that the home office of my therapist will be a private, secure location and that any records stored at the home office will be kept in a secure, locked location.
I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my therapy session could be disrupted or distorted by technical failures; the transmission of my therapy of my personal data could be accessed by unauthorized persons (e.g. my email address).
I further understand that there is a risk of being overheard by anyone near me if I do not place myself in a private room. As the client (or guardian of a client), I am responsible for creating a comfortable, safe environment at my end of the transmission. It is the responsibility of the therapist to do the same on their end.

In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.
I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
I understand that I have a right to access my therapy records in accordance with Saskatchewan law, the standards of the professional association to which my therapist belongs and the protocol of my individual Employee Assistance Program, if my sessions are paid for by an Employee Assistance Program.
I understand that, as per the ethical guidelines of the Saskatchewan Association of Social Workers, teletherapy services can ONLY be provided to those residing in Saskatchewan at the time of service.
I also understand that teletherapy may not be covered by my insurance plan or EFAP, and that it is my responsibility to check with my plan to determine if teletherapy is authorized. My therapist may also have information about coverage and I am encouraged to ask my therapist about known information. The client will ultimately be responsible for all fees related to teletherapy that insurance or EFAPs do not cover.

Teletherapy will be billed at the same rate as face-to-face services. I may pay for services by phoning the office and providing a credit card number or e-transfer.
I understand that my receipt will be provided to me through e-mail, text, mail or any other arrangement that's mutually agreed upon.
I understand that due to the nature of emails and texts the privacy through the transmission of these or any documents cannot be guaranteed.
I understand that neither party will record any of the sessions.
I understand and agree that certain situations, including emergencies and crises, are inappropriate for teletherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or Saskatoon Mobile Crisis Intervention Services (306-933-6200).
I authorize that crisis arising during sessions can be assisted by contacting my emergency contact person and/or family physician.

I have read and understand the information provided above. I have had the opportunity to discuss the information with my therapist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to participate in (or have my minor child participate in) the use of teletherapy services under the terms described herein.

_____ _____

Printed name of client Name of Therapist

_____

Signature of Client or Guardian(s)

_____

Signature of Client or Guardian(s)

Date: / /20

DD/MM/YR

_____

Signature of therapist

Date: / /20

DD/MM/YR

Phone number(s) to be used if Doxy.Me is not functioning optimally:

- -

_____

DD/MM/YR

Emergency contact name and relationship to client:

Contact Name: _____

Relationship: _____

Emergency contact phone number(s):

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Note: <u>Location</u>> we will discuss with each session. Please make sure you are in a private place where you cannot not be heard at ears length and interrupted!!

Family Physician Name and Phone number:

Physician:

Ph: - -
