



Linda Popielarczyk, MSW, RSW, Acc.FM (OAFM)

Email: lindapop.connections@gmail.com

Consent to Therapy/Counselling Services

DATE: _____

NAME: _____

ADDRESS: _____

TELEPHONE: **(H)** _____ **(B)** _____

(CEL) _____

Email _____

NAME: _____

ADDRESS: _____

TELEPHONE: **(H)** _____ **(B)** _____

(CEL) _____

Email _____

NAMES OF CHILD/REN:

_____	DOB	_____
_____	DOB	_____
_____	DOB	_____
_____	DOB	_____

Consent to Psychotherapy

Your informed consent is sought for the services being provided. This service agreement outlines the services being offered, the cost involved, and what is done with the personal information gathered about you. If you have any questions, please ask.

The purpose of therapy is to improve your emotional and psychological health and/or that of your child. Therapy methods will vary depending on the problem and treatment goals you and/or your child wish to address. Treatment suggestions will be discussed with you and/or your child, as well as therapy methods and techniques. The potential benefits, limitations and possible risks of treatment, the prognosis and possible alternative approaches will also be discussed to the extent that sufficient information has been gathered. You should be aware that you have the right to a second opinion and to terminate therapy as you see fit.

Ms. Popielarczyk is a member of the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Concerns regarding her conduct may be reported to the OCSWSSW. She is responsible for discussing the fee and payment arrangements with you as early as is reasonably possible, as well as the **cancellation policy**, which requires 48-business hours notice for missed appointments. Without such notice, you may be charged for the appointment that was held for you.

Confidentiality and Records

Sessions with Ms. Popielarczyk and the information discussed are confidential. That is, the contents of a session, or even whether or not you attend, will not be revealed to outside sources unless you have given written permission to do so, or as required by law. Instances in which confidential information may be disclosed are as follows:

1. In situations where there is a court order or summons presented to Ms. Popielarczyk

- for her attendance in Court, she is legally required to attend or submit any requested information or documents.
2. In situations where there is reasonable suspicion that a client intends to cause physical harm to him/herself or to another person, steps would be taken to offset the consequences of such action.
 3. The Regulated Health Professions Act makes it mandatory to file a report when the practitioner has reasonable grounds to believe that another member of the same or different college has abused the client.
 4. The Child and Family Services Act compels a practitioner to report to the appropriate child welfare agency concerns about the safety of a child (to include physical, sexual, or emotional neglect, harm or abuse) and the information on which the concern is based .
 5. If the College of Social Workers conducts an audit of the practice files, for quality assurance purposes.

For situations when there is more than one person receiving therapy (e.g., couple, marital, family or parent-child), the record may be combined or separate for each individual, depending on the circumstances. Notwithstanding, the consent of all participants is necessary to release any information or the record, subject to the limitations or expectations noted above in #1-5.

ELECTRONIC PROVISION OF SERVICES

Scheduling may be done by e-mail or telephone.

Electronic provision of services includes e-mail and video contacts (e.g., FaceTime, Skype) or communications by telephone and may be provided with your informed consent. The risks include insufficiency, misunderstandings due to lack of visual clues and technology failure. The benefits include appropriateness, avoids the need to travel a distance, taking less time off work, services continuing while Ms. Popielarczyk is away, convenience and comfort. Alternatives to the provision of electronic services include in-person services only or local services from an available health service provider of the same or different discipline.

While efforts are made to protect privacy, the same degree of confidentiality provided

Linda Popielarczyk, MSW, RSW, Acc.FM (OAFM)
Consent to Therapy/Counselling Services

during in-person office sessions is not possible; limitations include the possibility of interceptions of communications.

Please keep in mind that others may be able to access information, sensitive or otherwise, communicated electronically by you to or received from Ms. Popielarczyk, in your own home or work place. By signing this health consent form you are confirming to Ms. Popielarczyk that you have taken reasonable steps to secure your own electronic devices you choose to use to communicate with her (phones, ipads, computers, etc.). This would include having a confidential password and adequate firewalls. Any communications sent by Ms. Popielarczyk are intended for you and not for others, unless agreed to otherwise.

CONSENT FOR THE COST OF SERVICES

The fee for this therapy will be \$_____ per session. The full session fee will be charged for missed appointments that were not cancelled within 24 hours.

Administrative fees will be charged for requests for file notes (for time and duplication costs), reviewing files/notes and writing reports. All billing outside the direct contact time will be discussed prior to it occurring.

Payment for therapy may be paid by cheque, cash, VISA or Mastercard, at the end of each session, or by email transfer in advance of the meeting. Receipts may be provided when payment is received, or on a monthly basis. Please retain these receipts for your insurance or income tax claims, if applicable.

I understand that I have contracted with Linda Popielarczyk, MSW, RSW, for social work services. The fees are \$_____/hour, payable in advance by email transfer, or by cash, cheque, VISA or MC at the end of each session. I acknowledge that cancellations with less than 48 hours notice will be billable at the hourly rate.

Signature: _____ Date: _____

_____ Date: _____