CONSENT TO SERVICES FORM

We would like your informed consent for the services provided at the Age To Age Inc. *If you have any questions about any of this, please do not hesitate to ask.*

I/we, _____ give permission and consent to share information to Age To Age Inc. staff.

- I understand and have been advised by my therapist that, should it become necessary due to COVID -19 circumstances, my identifying information may have to be released to relevant authorities with respect to requirements pertaining to adhering to contact tracing procedures, and I consent to the same. I acknowledge, should I contract COVID-19, the therapist/clinic will not be liable.

- I/we understand that psychotherapy/social work/other support entails both benefits and certain risks, and that there is no guarantee that it will be successful. I understand that it is important that I mention promptly any concerns or questions I have at any time during the process of therapy.

- The usual therapy session lasts 50 minutes. The number of sessions will vary according to the Treatment Plan.

- **Session fees will be applied for missed and/or scheduled appointments cancelled less than 24 hours in advance** except in cases of emergency.

Confidentiality and the Limits of Confidentiality

Confidentiality is always respected. No information will be communicated directly or indirectly to a third party without your informed and written consent. Exceptions to confidentiality include the legal and/or ethical obligations to:

- Inform a potential victim of violence of a client's intention to harm
- Inform an appropriate family member, health care professional, or police if necessary, of a client's intention to harm/kill themselves or others.
- Release a client's file if there is a court order to do so
- Inform the Children's Aid Society if there is suspicion of a child being at risk or in need of protection due to neglect, or physical, sexual, or emotional abuse
- Report a health professional who has sexually abused a client to the professional's regulatory College
- Facilitate an investigation or inspection if authorized by warrant or by any provincial or federal law (e.g. a criminal investigation against the member, his/her staff, or a client). Or in accordance with the Missing Person's Act, 2018

Privacy of Personal Information

I understand that in order for Age To Age Inc. to provide me with psychological services, some personal information will be collected about me (e.g., name, address, telephone number, health history, and social situation) in order to help assess what my needs are. This information will then be used to advise me of my treatment options and to help me receive the treatment that I choose. I understand that during business, office staff may need to access some of my personal information (e.g., address for billing purposes, extended insurance information) and that this access is limited. I understand that I have the right to review and the right to a copy of my personal information, barring a few exceptions. I agree to ATA collecting, using, and disclosing personal information about me as set out in ATA's Privacy Policy, and that a complete copy of the Privacy Policy is available upon my request.

In Case of an Emergency

Emergency services are not available. In the case of an emergency, clients should dial 911, contact their Family Practitioner, or go to the Emergency Department of any hospital.

Informed Consent

I have read and understood the information presented in this document, and hereby consent to psychological treatment and/or assessment.

I understand how the Privacy Policy at Age To Age Inc. services applies to me and have been given a chance to ask any questions I have about the privacy policies and practices and they have been answered to my satisfaction. I agree to ATA collecting, using, and disclosing personal information about me as set out above and ATA Privacy Policy.

Release of Information

Individual or representative of organization	***Initial or check (√)***
Insurance Company	Yes ☐ No ☐
Legal Representative	Yes ☐ No ☐
Family Doctor	Yes ☐ No ☐
Other Treating Professionals	Yes ☐ No ☐
Other	

Additional Comments:

_____

I understand and agree with the above statement and, if requested, have received copy of the same.

Signature of Client: _____ ***Date:*** _____

Printed Name: _____

Note: The consent form needs to be signed by all clients competent to consent to psychotherapist services.