PsychSolutions, Inc

MINOR/CHILD CLIENT SERVICES CONTRACT / CONFIDENTIALITY AGREEMENT

16880-111 Ave Edmonton, AB, T5M 4C9

1. PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

You are also aware that my professional support is meant to assist in the functioning of your child(ren) and/or family. If you are in need of formal assessment services related to separation and divorce you will need to connect with a professional that specializes in this area of work.

2. RISKS AND BENFITS

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

3. COLLECTION & STORAGE OF PERSONAL INFORMATION

Personal information will be collected to ensure I have the information required to bill you for services rendered or for late cancellations/no-shows, to contact you when needed, and to ensure I have the documentation needed to provide you with appropriate services and/or referrals. If you choose to use online scheduling or payment, then your personal information will also be stored on these servers. Any personal information that is collected will be stored in a secure and locked location. If information is stored electronically, then it will be password protected. If you require me to share any of your personal information or speak on your behalf with a third party, you will need to sign a written Release of Information Consent Form first.

4. FEES

My fees are set according to the Psychology of Alberta Association's Professional Fee Guidelines. Registered Psychologist fees are currently set at $200 for individual or family sessions. Therapy sessions are 50 minutes in duration or intervals thereof. Payment is due each session. Billing occurs in 10-minute increments for services done outside the therapy session such as phone calls and letters. This is calculated at one-fifth the session rate for each 10 minutes.

If you are accessing services through an employee assistance program, then the costs of approved sessions will be covered through your EAP, unless you cancel an appointment with less than 24-hour notice or fail to attend an appointment. Additionally, whole or partial reimbursement may be available through your extended health care plan.

If the therapist agrees to receive third party payments for full or partial compensation for the services provided, and these third-party payments are not received by this therapist in full within 30 days of the invoice date, you agree that you will pay any balance remaining for the services provided by the therapist.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims

Court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

5. CANCELLATION / RESCHEDULING POLICY

Unless you provide 24-hour notice, you will be responsible for the full cost of your session. Further sessions will not be arranged until late cancellation/rescheduling or no-show fees are paid. If payment is not received, then your file will be closed.

6. CONFIDENTIALITY & LIMITS

☐ As a psychologist, I am registered with the College of Alberta Psychologists (CAP), a professional association, and I am bound by their professional Code of Ethics.

☐ As a social worker, I am registered with the Alberta College of Social Workers, a professional association, and I am bound by their professional Code of Ethics.

Your information will be strictly confidential, and no information will be released without your knowledge and written consent with respect to the following exceptions:

- If there is a concern that you are at risk of harming or killing yourself or someone else,
- Cases of suspected child neglect or abuse,
- If I receive a subpoena or summons from the courts or Workers Compensation Board,
- If you arrive under the influence of alcohol or drugs and you insist on driving (and refuse alternate arrangements),
- If a medical emergency arises,
- Third Party Payment and Insurance companies are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.
- In the event of a client's death, the spouse or parents of a deceased client may have a right to access their child's or spouse's records.
- Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions related records may be released in order to substantiate disciplinary concerns.
- When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies and the client's report may state the amount owed, time frame and the name of the office. I may occasionally find it helpful to consult other professionals about a case.
- I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client(s). I am also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

As an added measure to protect client privacy, I also make it a policy to not approach clients while in a public setting. Clients, however, are welcome to approach me if they would like to exchange greetings. It is understood that if I inadvertently violate the client's privacy or confidentiality, then I will notify the client as soon as the breach is noticed.

7. EMERGENCY CONTACTS / COMMUNITY CHAMPION

Emergency Contact: (Name/Role):_____(Phone):_____

Emergency Contact: (Name/Role):_____(Phone):_____

The above emergency contact person(s) will be contacted under the following conditions:

The role of the emergency contact / community champion will be to:

- ☐ provide client history
- ☐ monitor mood and behavior

- ☐ assist with treatment planning and coordination
- ☐ provide additional means of contacting client if connection lost
- ☐ provide onsite technical assistance if using telepsychology
- ☐ provide support to client during emergency situations.

8. ADDITIONAL CONFIDENTIALITY LIMITS FOR MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to access personal information shared in therapy. It is my policy to request an agreement from parents that they agree they will not access your private information shared in therapy so that you have a private place to work on any concerns you may have. If they agree, I will provide them only with general information about our work together that will let them know about your progress and how they can support you as parents. I will also share any concerns I may have about you if I think there is a high risk that you will seriously harm yourself or someone else. If requested, I may also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections or concerns you may have with what I am prepared to discuss.

Minor - By signing here, you are stating that, as a minor, you understand the above and that your parent(s)/guardian(s) may have the legal right to view your treatment records.

Minor's Signature: _____ Date: _____

Parent(s)/Guardian(s)- By signing here, you are stating that, as a parent/guardian, you understand the above and that you also agree that you will respect your child's privacy and to not access the personal information they share in therapy.

Client's Signature: _____ Date: _____

9. SUPERVISION OF MINORS

By agreeing to receive services from myself for your child, you also agree to and understand that my waiting room is not supervised and that there is no receptionist monitoring it, therefore their safety cannot be ensured. You understand that it will be in the best interest of your child that they are supervised at all times while in the building or in my waiting room. This supervision can be provided by myself or another trusted adult of your choosing. This requirement for supervision also includes dropping off or picking up your child or when you may need to leave the waiting room for a bathroom break. If you are late to pick up your child and I am required to supervise them, then the time I spend supervising your child will be charged to your bill. If you choose to leave your child unsupervised, then you understand and agree that I cannot not be held legally responsible for your child's well-being and safety. Finally, parents are also expected to return 15 minutes prior to the end of their child's session if they must leave while the child is in a session. You may be needed by the therapist for consultation.

10. TECHNOLOGY & POLICIES

Electronic communication should be used only for the purposes of scheduling or sharing of non- confidential information. All electronic communication may be considered as part of your clinical file and legal record. Although there are some potential benefits to communicating through email or text, such as increased accessibility and client convenience, you understand that the security and confidentiality of electronic communication cannot be guaranteed. You understand that some risks of electronic communication may not yet be known.

If you use these methods to communicate with me there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with me.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

You also understand that my time spent reading and replying to the information you send me will be charged to your account. Additionally, electronic communication is also not appropriate for emergency-based services. If you are in crisis, you understand that you will need to contact community emergency programs. If there is confidential information to be shared, please share this information by phone or in person. If after discussing the above risks and benefits, you would still like to communicate with me via non-secure electronic means, then please sign the consent for transmission of protected health information by non-secure means below.

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within 48 hours (weekends are excepted from this timeframe.) I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible. Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town. To ensure your safety, however, if you do not respond to my email or telephone call within 48 hours, then I may use my discretion to contact your champion or emergency contact to ensure you are safe.

11. TERMINATION OF THERAPY

Both you, as the client, and I, as the therapist, reserve the right to terminate therapy at any time at our own respective discretions. Reasons for termination by me may include, but are not limited to, untimely payment of fees, conflicts of interest, if your child's needs are outside of my scope of competence or practice, or the unauthorized use of any recording device with the signed consent of both myself and the client(s). Upon either party's decision to terminate therapy, I will generally recommend that you participate in one termination session which is intended to facilitate a positive termination experience and give both of us an opportunity to reflect on the work and future steps to be taken.

12. LIMITS OF SERVICES PROVIDED

Since this case involves child-clinical work, the Therapist shall not discuss this case with any person other than the parent(s) or those with legal custody, unless written consent is provided, or by Court Order or if a Parenting Coordinator is involved. In the case of 'Child and Family Services' involvement, regular communication with the Caseworker will occur. The only exception to this clause is for professionals that the Therapist consults with, while maintaining confidentiality, for continued professional development and to assist with case conceptualization and planning.

The Therapist will not provide a formal, written report for court, lawyers, or other legal systems. A written report shall also not be provided for regular counselling services. In the case of 'Child and Family Services' involvement, regular written progress reports will be completed.

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I / We_____affirm that I am the legal guardian of_____.

I / We understand that services are being sought for_____are for the purposes of therapy and not for litigation/court purposes. This service is to be conducted by PsychSolutions, Registered Psychologist (Registration #3608). I am aware that PsychSolutions is registered with the College of Alberta Psychologists.

I / We have read and understand the contents of this Client Services Contract and Confidentiality Agreement and voluntarily consent to the counseling and/or play therapy/assessment for the child named above terms and to the agreements set out in this contract. I understand that the use of any recording devices without the signed consent of both myself, the client(s) and the psychologist is prohibited. Any violation may result in the termination of the services.

Purpose(s) of Engaging the Therapist - As of this date, it has been agreed that, the Therapist, PsychSolutions, will render the following services:

___Parent Consultation
___Individual Counselling – Child/Adolescent
___Family Counselling
___Other: _____

My/Our questions have been answered to my/our satisfaction in language that I/we understand. By signing below, you are agreeing to the above and declare that at the time of your signing, all blanks were filled in.

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Therapist's Name: _____

Therapist's Signature: _____ Date: _____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS.

I consent to allow PsychSolutions to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments.
- Information related to billing and payment.
- Requested letters and/or Confirmation of attendance.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____
(Signature of client) Date

CONSENT FOR E-NEWSLETTER

I also consent to have the following email address added to the e-newsletter "Updates & Resources from PsychSolutions." I understand I can unsubscribe at any time without prejudice or penalty.

Email Address: _____ Client's Signature: _____