MIND MULTITUDES
MENTAL HEALTH & WELLNESS CLINIC

# Consent for Treatment and Limits of Liability

**Limits of Services and Assumption of Risks**:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, and discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

**Limits of Confidentiality**:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

**Duty to Warn and Protect**

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

**Abuse of Children and Vulnerable Adults**

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e., the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers**

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

Given my written and informed consent, Mind Multitudes will provide copies of my assessment/progress reports and treatment plans to my legal representative, family physician, or other treating practitioners.

**Distance Counselling**

I understand that while appointments may take place in person at my therapist's office, which has undergone quality checks to ensure client confidentiality is maintained, sometimes appointments may not take place in person, but through distance counselling via telephone or a secure, web-based videoconferencing platform (i.e., ZOOM). I understand that reasons for accessing appointments via distance counselling include but are not limited to, physical distancing protocols, a client's physical or mental health limitations, a client's geographic location, inclement weather, etc. I further understand that the distance counselling platform available through Mind Multitudes offers an online platform for healthcare providers to provide service to their clients via Personal Health Information Protection Act, 2004 (PHIPA)-compliant, encrypted video conferencing. The platform is easy to use and delivers the highest level of security in video conferencing technology in healthcare.

**PRIVACY OF PERSONAL INFORMATION**

I understand that for me to be provided with counselling services, my therapist will need to collect some personal information about me. I understand that Mind Multitudes administrative staff may need to access some of my personal 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 rare exceptions.

I understand that my clinical record will be securely kept on an electronic health record platform; however, a hard copy of this clinical file may be created for convenience and will be kept until it is securely uploaded to the electronic health record platform, at which time it will be destroyed as per PHIPA guidelines.

I understand that my clinical record will be retained for a minimum of 10 years after the date of my last contact with my therapist, or a minimum of 10 years after my/my child's 18th birthday if I/my child was under the age of 18 during treatment, after which my clinical record may be destroyed. I understand that all record destruction is completed in a manner compliant with the PHIPA standards to ensure my privacy is maintained at all times.

**INSURANCE COMPANY'S REQUEST FOR AUDITING A CLIENT'S INVOICE**

I understand that insurance companies regularly audit client invoices to confirm if the service took place. By signing below, I agree that Mind Multitudes can provide my insurance company with non-health-related information (e.g., appointment dates and times, length of sessions, etc.) relevant to my claim with the insurance company.

**PAYMENT POLICY**

- 60-minute sessions: $180 + HST
- Initial sessions: typically, 90 minutes in length to allow for an intake assessment
- A sliding scale rate is possible depending on financial circumstances.
- Work done outside of sessions (letters, reports, resume writing, check-in calls over 10 minutes, offsite services, etc.) is also charged by the hourly rate.
- Payment for sessions will be required 24 hours from the time of your appointment.

**CANCELLATION POLICY**

If you are unable to attend an appointment, we request that you provide at least 48 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 2 hours ' notice (unless due to severe illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

**MIND MULTITUDES MENTAL HEALTH AND WELLNESS CLINIC**

Due to the changing world of healthcare and technology, Mind Multitudes and representatives working with our clinic who contact our clients can provide information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, from Mind Multitudes and representatives please complete the form below.

Please print all information neatly and legibly.
Name_____
Names of Children under 16:
_____
E-mail address_____
Cell Phone_____
□ Yes, please sign me up to receive e-mail and text messaging confirmations.
□ I do not wish to be contacted via email. (Text messaging only)
□ I do not wish to be contacted via text messaging. (Email only)
□ I do not wish to be contacted by either text messaging or email.
I hereby give Mind Multitudes permission to send messages to me via email and/or text messaging as a means of communication as indicated by my selection above.
Please sign below to state that you do understand the above office policies:
Dated this _____day of _____, 20_____

_____
Patient Signature (or Legal Guardian) Witness Signature

_____
_____
Patient Name (Please Print) Witness Name (Please Print)

**INFORMED CONSENT**

I have read and understood the information presented in this document, and hereby consent to the services described above.

I understand that, in accordance with the Health Care Consent Act, there is no minimum age for consenting to treatment. However, consent must be informed. In other words, the person giving consent has the capacity to understand and appreciate the nature and consequences of giving and withholding consent to engage in counselling services. If the client is incapable of making decisions with regard to accessing treatment and/or the disclosure of their personal health information, then their substitute decision maker or custodial parent/legal guardian has to authority to do so on their behalf.

**Agreed-Upon Fee:** _____

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**Client's Signature** **Date**

**NOTE**: The consent form needs to be signed by all clients competent to consent to counselling services.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date