Telephone Informed Consent

The purpose of this document is to provide informed consent to the client for therapeutic services *(therapy)* provided by the Red Deer Primary Care Network (RDPCN).

Read it carefully before signing, after asking for, and receiving satisfactory answers to any questions you may have.

Purpose and Nature of Therapy the RDPCN provides brief counseling therapy.

At this time, and due to the COVID-19 virus pandemic, I understand that the counselor wishes that I engage in telepsychology therapeutic services – therapy via the telephone; and if possible, using email for sending/receiving relevant forms *(e.g., the two part informed consent forms).*

The counselor explained to me how the telephone and email technology would not be the same as a direct client/counselor in-person visit. The counselor and/or myself may miss, or misunderstand, typical conversational/visual cues. Counselors and clients should both ask for clarification if need be.

The counselor and I identified and discussed strategies for managing potential boundary issues *(e.g., email messaging).*

There is no fee charged to the client for the Therapy.

RDPCN counselors do not complete return to work, psychological or custody assessments. The RDPCN will direct requests for information from Insurance companies to your family doctor.

Mutual Responsibilities The counselor will provide competent research-based therapy.

The client is responsible for asking for what they need during therapy, and for being open and honest with the counselor.

The client will need to apply what they have learned in the therapy, and follow through on the tasks or homework assigned by the counselor, in order to achieve the maximum benefits of the therapy.

The Therapy provides many benefits but, at times, can be uncomfortable for the client. It is up to the client to decline to answer a question or take part in an activity if that is their preference. The client can and should ask questions, seek clarification or discuss their reluctance or concerns about any aspect of the therapy with the counselor.

As part of our commitment to providing quality service, we occasionally ask to record sessions for later review. This can provide your counselor an opportunity for feedback to, among other things, improve their counselling skills, identify what is going well, or gain more ideas to support you in further sessions. We will provide you with a consent form outlining details that are more specific if this occurs.

Confidentiality The RDPCN and the counselor keep all information shared by the client with the counselor through the course of therapy confidential within the group of primary care health care professionals.

The counselor will enter a note about what happens in therapy, along with any relevant email messages exchanged with the counselor, into the client's medical file at their doctor's clinic. Clinic staff may add and/or scan these documents into the file, and the family doctor will have access to see these notes. Neither the RDPCN, nor the counsellor will release any confidential information to any other party without written permission except in the following situations:

a. If there is a risk of harm to the client or others.

b. If there is a risk of harm to a child or other vulnerable person.

c. If a lawyer subpoenas the records for a court case.

Benefits and Risks I understand that telepsychology therapeutic services has potential benefits including easier access to care and the convenience of communicating from a location of my choosing.

I understand there are potential risks to telepsychology, including interruptions, risk of distractions, unauthorized access, time delays, equipment failure, and technical difficulties; the Counselor discussed additional confidentiality and risks associated with telepsychology *(e.g., others overhearing the conversation, accessing of email by others, possibility of hackers).*

AlternativesI understand that the counselor or I can discontinue the telepsychology therapeutic services if it is felt that the therapy is not adequate for the situation; I was informed what might happen should the counselor determine that I would receive greater benefit from in-person or other services.

Consequences of No Therapy Without the therapy, there may be no improvement in the condition of the client and their condition could worsen.

Refusal and Withdrawal The client may refuse counseling at any time and may withdraw from counseling at any time by telling their counselor.

Term of Consent- Consent will expire upon the termination of the therapy.

By signing this form, I certify:

That I am the client *(or guardian of the client).*

I have had a direct conversation with the counselor, and I have read, or had this form read, and/or had this form explained to me, in a language that I understand.

The counselor has informed about the Therapy that I/ *(name of minor or dependent adult)* will receive, including telepsychology therapeutic services.

That I fully understand its contents including the risks, benefits, and alternatives to, the therapy.

That the counselor gave the opportunity to ask questions about any aspect(s) of the therapy, and answered them to my satisfaction.

I, _____, acknowledge that I consent to therapy proceeding on the above terms.

Client /Guardian Signature: _____ PHN: _____

Mental Health Counselor Signature: _____ Date: _____

Referring Physician: Dr. _____