

PROGRAM PARTICIPATION CONSENT

Purpose

The purpose of this form is to obtain your consent to participate in virtual/in-person Art Therapy and/or Music Therapy sessions with ICS NRIO's certified Art Therapist and/or Music Therapist.

Confidentiality

The laws protecting your confidentiality of your information also apply to virtual. Information regarding your virtual sessions and any other personal information you share will be kept strictly confidential except under the following circumstances: in cases of suspected child abuse and in cases where bodily harm to yourself or another person is threatened, your therapist is required by law to inform the appropriate authorities; if your therapist is subpoenaed to provide information regarding your sessions in a court of law. Please note that while all attempts to establish and retain a secure connection online or via telephone have been made, it is at times not possible to guarantee 100% protection of the confidentiality of telephone/online communication.

Session Safety Requirements

Given that virtual sessions means that client and the Therapist are not physically located in the same place, an extra step to ensure client safety is required. You will be required to provide the physical address of your location at the beginning of each telephone or online appointment.

Ensuring the Privacy of Your Session

It is essential that you feel comfortable during your session. Please make arrangements to be in a room where you will not be interrupted. For virtual sessions, your Therapist will ensure that they are in a room alone with a closed door free from distractions in order to provide you with their full attention.

Rights

You may withhold or withdraw consent to sessions at any time.

I agree to participate in virtual/in-person sessions.

Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

FUNDER INFORMATION

MVA Insurance Company

WSIB

Private

Adjuster / WSIB name:

Address:

Phone number:

Email / Fax number:

Claim # (if applicable):

Private Pay Agreements (if applicable):

Name: _____

Relationship to participant (if applicable): _____

Contact number: _____

Address:

Method of Payment:

Credit Card

Cheque

* Payments must be made in advance of the program start date to secure program registration. All credit card numbers must be provided over the phone to Dianne Roach at (416)231-4358 ext. 32612 or Jenifer Goodine at ext. 32738.

REFERRAL INFORMATION (please include injury and impairment information)
