**ICS NRIO’S VIRTUAL ART & MUSIC THERAPY PROGRAM**

Thank you for your interest in our program, we can’t wait to get you started!

Please note, virtual sessions will be taking place via Teams, and will therefore require a computer/laptop with a camera and audio function, as well as a WiFi connection. In person sessions will be held at NRIO’s head office at 59 Beaver Bend Crescent. All sessions are conducted by certified neurological therapists.

**I AM INTERESTED IN:***\*Check all that apply.*

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| **ART THERAPY** |
|  **1 ON 1 SESSIONS**  |
| Focusing on emotional and mental health and healing through art therapy. Sessions are 50 minutes each, for a minimum of 4 weeks |
| **GROUP SESSIONS**  |
| Weekly creative projects around light themes and topics; opportunity to meet other participants, build a sense of community and socialize. Sessions are 60 minutes each and run weekly on Monday’s (in-person) and Saturdays (virtual).  |

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| **MUSIC THERAPY** |
| **1 ON 1 SESSIONS**  |
| Focusing on emotional and mental health and healing through music therapy. Sessions are 50 minutes each, for a minimum of 4 weeks |
| **GROUP SESSIONS**  |
| Weekly sessions, offering opportunity to meet other participants, build a sense of community and socialize. Sessions are 60 minutes each and run weekly on Thursdays (in-person) and Sundays (virtual).  |

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| **Group Therapy Costing Options** |
| **Monthly:**1-Month (4 sessions): $160.00 +HST3-Month (12 sessions): $480.00 +HST**Flexible:**6-Months (can attend up to 2 art or music sessions per week): $950.00 +HST |

**GETTING TO KNOW YOU!**

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| **Name**  |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Medical Condition / Special Needs** |  |
| **Interests / Hobbies** |  |
| **If interested in 1on1 sessions, please indicate your availability for sessions (e.g. Tuesdays between 1-5PM)**  |  |
| **Contact Information** | **Name / Relation (if not client):**  |
| **Phone Number:**  |
| **Email Address:**  |
| **Preferred Method of Communication** | **Email Phone Call Text Message**  |

**PROGRAM PARTICIPATION CONSENT**

**Purpose**

The purpose of this form is to obtain your consent to participate in virtual 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.

**Virtual 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 Virtual Session**

It is essential that you feel comfortable during your online session. Please make arrangements to be in a room where you will not be interrupted. 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 virtual sessions at any time.

I agree to participate in virtual sessions with my School Resource Specialist.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INSURER INFORMATION (if applicable)**  |
| Insurance Company: Adjuster name: Address: Phone number:Fax number:  |
| Claim #:  |
| **LEGAL REPRESENTATIVE (if applicable)** |
| Law Firm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REFERRAL INFORMATION (please include injury and impairment information)** |
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