TURNING POINT
PSYCHOLOGICAL SERVICES

CONFIDENTIAL PATIENT INFORMATION

Patient Name: ____

Date of Birth: ______________________ **Gender:** ____________

Occupation: ______________________

Email: ____________________________

Address: ____

____

Home Phone: _________________ **Cell Phone:** _____________

Emergency Contact Person:

Name: ________________ Relationship to Patient: _________________

Telephone: __________________

Referred by: _________________________

For International clients only:

Your country's emergency services number: _______________

TURNING POINT
PSYCHOLOGICAL SERVICES

FOR PARENTS OF CHILDREN UNDER 16 YEARS OLD

Name/s of person/s filling out this form: ____

Relationship to child: ____

Parents are currently: Married__ Separated__ Divorced__ Remarried ____________

Other (Specify) ____

Child's legal guardian/s (custodial parent/s):

____

Guardian (1) name: ____________Relationship to child __________________________

Address: ____

Cell: ________________________ email ______________________________

Guardian (2) name ____________ Relationship to child __________________________

Address:

____

Cell: ________________________ email ______________________________

Any other address/es from which the child may connect to telehealth session:

____

____

____

CONSENT FORM

Name/s of Patient/s: ____

This form is to document that I/we give permission and consent to Anna Prudovski, M.A., C.Psych., a certified member of the College of Psychologists of Ontario, to provide psychological consultation, assessment, and/or treatment to me/us and/or
my child____
I understand that I/we have the right to withdraw consent for psychological services at any time.

I understand that Anna Prudovski, M.A., C.Psych., the Clinical Director of Turning Point Psychological Services (TPPS), is responsible either directly or through a supervised service provider, *Cassandra Grosso, BSc., Counsellor*, for all aspects of the psychological services provided to me/us or my child. I further understand that the supervised provider, though not a registered member with the College of Psychologists of Ontario, has the required training to deliver psychological services under the supervision of a Clinical Psychologist. When necessary, it is possible to schedule a phone call with Anna Prudovski, M.A., C.Psych., at my request, or at the request of the supervisee.

I understand that psychotherapy entails both benefits and certain risks, and that there is no guarantee that psychotherapy will be successful. I understand that it is important that I mention promptly any concerns or questions I may have at any time during the process of therapy to my therapist.

CONFIDENTIALITY

Confidentiality is respected at all times and no information will be released to a third party without my informed consent, with the following exceptions:

- If a patient is considered to be an imminent threat to her or his physical safety or to the safety of others.
- If there is suspicion of child abuse or neglect, the appropriate child welfare authorities will be notified.
- If a patient was sexually abused by a member of a regulated health profession.
- If a court orders the disclosure of records.
- If a patient reports abuse of an elderly person in a long-term care facility by staff.
- When insurance companies inquire about the dates of service and fees.

Initials: ___

PAYMENT FOR SERVICES & FEES

I agree to pay for all psychological consultations and counselling/ psychotherapy services provided to me/us or my child at the rate of $210 per hour. The usual hour is 50 minutes as set out by the Ontario Psychological Association. ***I agree to pay in full via an e-transfer prior to each session.***

In cases where a client is unable to send an e-transfer or when the e-transfer is not received prior to the session, the credit card transaction fees (3.5%) apply and the fee is therefore $218.
I agree that where I am unable to send an e-transfer or when the e-transfer is not received prior to the session, my credit card will be charged, the credit card transaction fee will apply, and my fee will therefore be* $218*.

Written reports, letters, emails, or other forms of written correspondence, meetings or court attendances including commute and wait time, phone conversations, and phone consultations with other professionals, will be billed based on the hourly rate.

A surcharge of $40.00 will apply to all N.S.F. cheques. A late fee of 2% per month will be added if payment is not received within 30 days of the date of service.
Outstanding accounts of more than 60 days will be eligible for submission for collection.

Please verify your coverage for our services or exclusions that may affect the reimbursement of claims with your insurance company. **Please note that we are not responsible for non-reimbursement by insurance.**

Cancelled and missed appointments:

There is a 2-business-day cancellation policy. If you are unable to attend your appointment, please notify us **2 business days** in advance, **otherwise, you will be charged the full amount of the session.** Notwithstanding illness or bad weather, late cancellations and no shows will carry responsibility for full session payment. Your understanding is appreciated. This policy enables us to run our practice and is in effect regardless of the reason for the cancellation.

Initials and signature: ______________________

Would you like feedback provided to your physician? Yes❑ No❑ Undecided❑

This consent form has been reviewed with me/us. I have had an opportunity to ask questions, and I/we understand its contents.

Date: ______________________________

Printed Name: ______________________________

Signature of Patient: ______________________________

CREDIT CARD AUTHORIZATION FORM

PLEASE DISREGARD THIS PAGE IF YOU ALREADY PROVIDED YOUR CREDIT CARD INFORMATION UPON BOOKING YOUR APPOINTMENT.

I:____
hereby authorize this card to be used by Turning Point Psychological Services for the psychotherapy sessions, as well as for missed appointments and cancellations with less than 2 (two) business days' notice and understand that 3.2% credit card transaction fee will apply.

Credit Card Information:

Name as it appears on the Card:

____

Type of Card: □ VISA □ MASTERCARD □ AMERICAN EXPRESS

Credit Card Number_______- _______- _______- _______ Expiration Date______/_____

CVV Number_______

Credit Card Billing Address: Street: ______________________________________

City: _________________________Province: ____________ **Postal Code**: _________

Telephone: _____________________________

E-Mail: _________________________________

Cardholder Signature: _____________________

Date: _______/________/________

Consent to Video Therapy

Patient Name: ___________________________________

1. I agree to engage in video therapy.

2. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate for the situation.

3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

4. I have had the opportunity review the information about video therapy, as well as the instructions on how to prepare for the online session on the therapist's website page at www.turningpointpsychology.ca/online-therapy. I had the opportunity to ask questions prior to the session by emailing the therapist prior to the video session.

By signing this form, I certify that I fully understand its contents including the risks and benefits of the video therapy and I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient's/parent's/guardian's signature: _______________ Date: ______________

EMERGENCIES AND TECHNOLOGY

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services.

Your provider will ask you to identify an emergency contact person who is near your location and who your provider will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your provider back; instead, **call the local emergency number or go to your nearest emergency room**. Call your provider back after you have called or obtained emergency services.

TURNING POINT PSYCHOLOGICAL SERVICES (TPPS) ELECTRONIC COMMUNICATION POLICY

Some common modes of electronic communication can put your privacy and confidentiality at risk. TPPS is unable to ensure privacy and confidentiality of any form of communication through electronic media.

Email and Text Messaging Communications

You may use text messaging or emailing with your therapist for the purpose of arranging and modifying appointments. Most clients find text messaging the easiest and fastest way of doing so. **We request, however, that you do not use these methods of communication to discuss personal circumstances or therapeutic content or to request assistance for emergencies.**

If you need to discuss a clinical matter with your therapist, please bring it up at your next session.

Social Media

We do not accept friend or contact requests from current or former clients on any personal social media sites as it may compromise your confidentiality. It may also blur the boundaries of the therapeutic relationship.

TPPS has a professional Facebook page to allow people to share our blog posts, practice updates, and psychology news with other Facebook users. You are welcome to view our professional Facebook page and read or share articles posted there. TPPS has no expectation that clients follow our page, this is left to our clients' discretion.

Websites

TPPS has a website https://www.turningpointpsychology.ca/ that you are welcome to access. We use it to provide information to others about us and our associates and our areas of practice.

The website also includes content that can be useful for preparing for your first session, reading materials for subsequent appointments, articles, ACT-consistent guided meditations, OCD test, obsessions and compulsions checklists, and other materials. You are welcome to access and review the information on the website and, if you have questions, your therapist will be happy to answer them.

If you have any questions about this policy, please feel free to discuss them with your therapist.

Please sign below to indicate you have read and understood the above.

Name: ____________________ Signature: ___________ Date: ____________________