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: _____

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, is responsible either directly or through a supervised service provider
Victoria Prooday, Registered OT, 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. If I wish to speak with Anna Prudovski, M.A., C.Psych., I may do so by calling 647-444-6030. When necessary, it is possible to schedule a meeting 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 consultation and counselling/ psychotherapy services provided to me/us or my child at the rate of $200 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***.

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

The fee is increased by $5 every January 1st.

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. **In any case, please note that we are not responsible for non-reimbursement due to insurance issues.**

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.** 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

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 business days' notice.

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 that video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/therapist visit due to the fact that I will not be in the same room as my therapist.

3. 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.

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

5. I understand that billing will occur via internet transfer that I email to my provider prior to the video therapy session. The therapist will email me a receipt after the session.

6. 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 and/or scheduling a phone call prior to the video session.

By signing this form, I certify:

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

Patient's/parent/guardian signature: _____ Date: _____

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 cannot 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, which is left to our clients' discretion.

Websites

TPPS has a website that you are welcome to access. We use it to provide information to others about us and our associates, areas of practice, and locations. The website also includes content that can be useful for preparing for your first session and reading materials for subsequent appointments. 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: _____