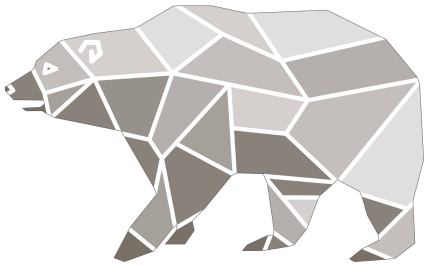

BEAR PSYCHOLOGY
TRAUMA PRACTICE

Baranowsky Psychology Professional Corporation
4789 Yonge Street, Suite 703
Toronto, Ontario
M2N 0G3
(416) 733-3838
office@bearpsychology.ca

TeleHealth Intake Form

Tele-Health (aka TelePsychology) Informed Consent Form

Note: The Ontario Psychological Association has recognized the provision of psychological services using telecommunication technologies that allow for the preparation, transmission, communication of processing of personal health information by electronic means. These technologies may include telephone, mobile devises, secure videoconferencing, secure forms of email, text, chat and some internet-based services (e.g., social media).

For more information on the use of email, please refer to the OPA Guidelines on Best Practices in Electronic Communications. https://bit.ly/33u6TQF

For more information on the use of social media, please refer to the OPA Guidelines on Best Practices in Social Media. https://bit.ly/2WukVQC

For more information on the use of social media, please refer to the OPA Guidelines on Best Practices in TelePsychology. https://bit.ly/2U12y4i

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I hereby consent to engaging in TeleHealth (aka. TelePsychology) with the mental health team at Baranowsky Psychology Professional Corporation (Bear Psychology) and the Trauma Practice for Healthy Communities.

As part of my mental health care, I understand that "TeleMedicine, TeleHealth or TelePsychology" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. I understand that TeleHealth also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Ontario, Canada.

I understand that I have the following rights with respect to TeleHealth.

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to TeleHealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self or an ascertainable victim; and where I make mental or emotional state an issue in a legal proceeding.

3. I understand that there are risks and consequences from TeleHealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the mental health professional, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that if my mental health professional believes I would be better served by another form of psychotherapeutic services, I will be referred to an alternate professional or service who can better meet my needs. Finally, I understand that there are potential risks and benefits associated with may form of mental health care. That despite my efforts and the efforts of my mental health professional, my condition may not improve and in some cases may get worse.

If you have an emergency, feel suicidal or homicidal please:

- Call 911
- Go to the nearest Hospital Emergency Department
- Call or visit a local Mental Health Emergency Department (i.e., CAMH)
- Call the Suicide Hotline (416) 408-4357

5. I understand that I may benefit from TeleHealth, but that results cannot be guaranteed or assured.

6. I understand that I have a right to access my medical information and copies of records in accordance with Ontario law.

If you have any questions about this form, or wish to speak with our team prior to signing, please do not hesitate to let us know. We are happy to assist.

office@bearpsychology.ca or 416-733-3838

☐ I consent to engage in remote therapy via voice / video technology.

Name:

Date: *(YYYY-MM-DD)*