Lakeside Natural Health
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Social Work Informed Consent – Child

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre.

Christina Hyland, M.S.W., R.S.W., earned her Honours undergraduate degree in Social Work from McMaster University and her Masters of Social Work Degree at York University. She is registered with the Ontario College of Social Workers and Social Service Workers and is a member of the Ontario Association of Social Workers. Christina has had Level 1 Certification training in Cognitive Behavioural Therapy at McMaster University and provides a range of counselling services to the public through professional and self-referral. Christina is committed to protecting the privacy of your personal information and has developed policies and procedures in compliance with the Personal Information Protection and Electronic Document Act, 2004 (PIPEDA) and the Personal Health Information Protection Act, 2004 (PHIPA).

The following information is to provide you with an idea of what to expect from our counselling services and to inform you about the person information that will be collected, how it is used, and how we protect its confidentiality and your rights of this information:

Confidentiality

Christina respects the privacy of her clients, holds in strict confidence all information regarding her clients and complies with applicable privacy legislation. No information will be released to a third party without your written permission. At any time, you have the right to withhold or withdraw consent, or place conditions on the disclosure of your information.

The nature of personal information collected may include:

Information required to maintain a working file according to the standards of our profession and the Ontario College of Social Workers and Social Service Workers such as your name, address, phone numbers, date of birth, other contact information, names of others who are significant to your situation (family, your doctor, and other professionals) and sometimes their contact information. We also collect information about our work and the social workers actions in this regard, any correspondence sent or received, any consents or other documents you have signed, copies of papers you have given us and other documentation particular to the nature of our involvement. Information necessary for billing purposes which may include information about your Assistance Program and their standards, information about other third party payers, copies of all receipts given to you including copies of electronic payments, copies of invoices and billing records and information related to the scheduling of appointments with you.

We collect this information for the following reasons:

1. To maintain a clinical file or working file that meets the standards of our profession and the Ontario College of Social Workers and Social Service Workers.
2. To provide this service for you in a manner that ensures your safety.
3. To maintain a high standard of professionalism in the provision of service.
4. To assist in the process of billing for my services.
5. To meet other legal and regulatory requirements.
6. To maintain records pertaining to the operations of a business and to make these records available if requested.

There will be times when we ask you if we may speak with others about you and your situation. There will be times when you will ask us to do this as well. On these occasions, we will always discuss this information-sharing with you and we will look at the benefits and consequences of speaking to others about your situation. We would then ask for your informed, written consent for me to share your information.

There may be occasions when we must share information about you or your situation without your written consent. These situations are very exceptional but may include the following:

1. If we have information about abuse or risk of abuse to a child then I must report this to the proper authority.
2. If we have a concern about any risk that you may do harm to yourself or harm to another person then I must take action to ensure your safety or the safety of others.
3. If we am required by law to release information such as receiving a subpoena to court.
4. When disclosure is needed to receive professional or legal consultation.
5. If we must defend myself against a complaint filed with the Ontario College of Social Workers and Social Service Workers or any other court action.

While these events are rare, we would like to help you become aware that these possibilities do exist. Our primary goal is to foster a safe space where you feel comfortable and able to explore and disclose personal concerns. If there are other limits of confidentiality in your situation, we will identify and discuss them with you before proceeding with your service. When we work individually with children and adolescents we will attempt to keep parents informed of their child's/adolescent's progress and attempt to keep parents involved in the therapeutic process. However, in the case of older adolescents, they are afforded the right to privacy.

There are times where we may also share pertinent anonymous information about certain clients within the confidential context of supervision, for the purpose of providing the highest quality care in the benefit of the clients. However, all identifying information such as your name will remain confidential. There will be times when you will ask us to do this as well. On these occasions, we will always discuss this information-sharing with you and we will look at the benefits and consequences of speaking to others about your situation. We would then ask for your informed, written consent for me to share your information.

We make every attempt to safeguard personal information. I would like you to know the following:

Your file contains all the personal information about you and your situation with the exception of copies of billing information such as receipts and electronic payments. Files are stored in a locked cabinet in a secure locked area. We do not store information about you in my computer. If we on occasion, prepare a document about you on the computer it will be stored on removable disc and thus removed from the computer. These discs are stored in your file. Your file is maintained according to regulations set by our profession and the Ontario College of Social Workers and Social Service Workers and in accordance with other legal requirements. When information about you is no longer required, it is cross-cut shredded and disposed of by me. In the event of incapacity or death, a designated social worker would have some access to your information in order to assist you in a transfer to another therapist or to maintain the file according to legal and regulatory standards. This social worker would also be a member of the College of Social Workers and Social Service Workers and would be obligated to provide all services to the same standard that I would.

We will ensure the security and preservation of your record for a period of 7 years after the last date of service provided. You have the right to request to see any personal information that we have collected about you or your situation or that of your custodial children under the age of 12. You have the right to review your clinical file. We will assist you to understand all of what has been written in your file. If you believe that some information about you is incorrect, you may request that the information be changed. We will then correct this information with any third parties who may have been given the wrong information. If you wish to view your file or if you have any concerns about the privacy of your information, please contact Jessica Liu, ND at Lakeside Natural Health Centre (905)-274-4375.

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Email Confidentiality

Every time you send a regular email, your messages and your privacy are at risk of being viewed, intercepted or modified by 3rd parties as your emails will be directed to the clinic reception. Christina recommends that clients request/schedule phone consultations if needed in between sessions, as Lakeside Natural Health Centre provides Christina with a secured confidential line. If you are experiencing a crisis and are unable to get in touch with Christina or reception to book an appointment, please contact the emergency department of the hospital nearest by. Christina accepts no liability for any interference with or damage to your computer system, software, or data occurring in connection with your use of insecure email to communicate with Christina and Lakeside Natural Health Centre.

Risks and Benefits

There are risks and benefits to the counselling process. Counselling may involve the risk of remembering unpleasant events and may arouse strong and/or unanticipated feelings. Benefits of counselling may be personal growth, where goals are achieved and new influential coping strategies are developed as tools to draw on in various areas of your life, such as interpersonal relationships, family, friends and career. You may also gain a deeper self awareness and understanding of yourself, your goals and your values. Given the nature of counselling, it is difficult to predict or guarantee any particular outcomes. However, Christina will do her best to help you experience its benefits beginning with where you are at and what areas of your life or concerns that you wish to focus on. Christina encourages open dialogue to discuss any questions or concerns with her at any point in therapy.

Informed Consent

Informed consent for counselling services is essential and out of respect for your right to self determination. Consent must be given voluntarily and knowingly. You have the right to change your mind and withdrawal informed consent at any time.

Statement of Informed Consent

I have read and fully understand the information contained in this document. Any and all questions I have regarding the contents of this document have been answered to my satisfaction and I would like to proceed with individual counselling.

Client Name (Please print name): _____

Signature of Patient or Guardian: _____ Date: _____

Social Worker Signature: _____

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: _____

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Social Work Consent to Release Personal Information

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Client Name (Please print name): _____

Date of birth (mm/dd/yy): _____

With my affixed signature, I hereby authorize _____ and Lakeside Natural Health Centre to give / receive / exchange:

(Circle one)

_____ Specific information: _____
Initials

_____ Any information: _____
Initials

To/From/With:

_____ Person and/or agency: _____
Initials

_____ Person and/or agency: _____
Initials

_____ Person and/or agency: _____
Initials

My signature indicates my understanding and agreement with this form.

Client Signature: _____ Date (mm/dd/yy): _____

Parent 1 Signature: _____ Date (mm/dd/yy): _____

Parent 2 Signature: _____ Date (mm/dd/yy): _____

Witness Name and Signature: _____ Date (mm/dd/yy): _____

*Please note that both parents signatures are required

*Consent for the Release of Personal Information can be revoked at any time by the request of above named client. Otherwise, this consent expires 6 months from the above date.

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Billing Authorization Form

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Credit Card on File:

Client's Name: _____

Name as it appears on the credit card: _____

Type of credit card (please circle): MasterCard / Visa

Card Number: _____

Expiration Date (month/year): _____

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, _____, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: _____ Date: _____

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Social Work – Child / Adolescent Intake Form

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care.

Contact Information:

Name _____

Date of Birth M_____D_____Y_____

Gender (circle) Male / Female Age_____

Address _____

_____

Emergency Contact _____

Emergency Contact # _____

Home # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Work # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Cell # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Email _____

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? _____

Parent(s) Information:

Name _____

Relationship _____

Date of Birth M_____D_____Y_____

Gender (circle) Male / Female Age_____

Marital Status _____

Address _____

_____

Home # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Work # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Cell # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Email _____

Name _____

Relationship _____

Date of Birth M_____D_____Y_____

Gender (circle) Male / Female Age_____

Marital Status _____

Address _____

_____

Home # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Work # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Cell # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Email _____

Step Parent(s) / Guardian(s) Information:

Name _____

Relationship _____

Date of Birth M_____D_____Y_____

Gender (circle) Male / Female Age_____

Marital Status _____

Address _____

_____

Home # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Work # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Cell # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Email _____

Name _____

Relationship _____

Date of Birth M_____D_____Y_____

Gender (circle) Male / Female Age_____

Marital Status _____

Address _____

_____

Home # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Work # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Cell # _____

May we leave a message identifying ourselves? (Circle): YES / NO

Email _____

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Sibling(s) Information:

Name _____ Name _____
Relationship _____ Relationship _____
Date of Birth M_____D____Y_____ Age_____ Date of Birth M_____D____Y_____ Age_____
Male / Female
Name _____ Name _____
Relationship _____ Relationship _____
Date of Birth M_____D____Y_____ Age_____ Date of Birth M_____D____Y_____ Age_____

Health Care Providers:

Type of Provider _____ Type of Provider _____
Name _____ Name _____
Phone # _____ Phone # _____

General Information:

Do you or your partner have insurance that covers Social Work Services for your child/adolescent? (Please circle): YES / NO
(Please note that we provide you with an invoice to submit to your insurance company for reimbursement as we do not bill direct to insurance companies).

Who does your child/Adolescent live with? _____
What school does your child/Adolescent attend? _____Grade:_____ Teacher: _____

How would you rate your child/adolescents current physical health? (Circle): Poor Unsatisfactory Satisfactory Good Very Good Excellent
Please explain: _____

Please describe the presenting concerns/goals for seeking counseling services? _____

How long have these concerns existed? _____

Would your child/adolescent like anyone else involved in the counselling with them? (Please circle): YES / NO
If yes please provide names and relationship to them: _____

Are you currently in treatment for any medical problems or taking medications? (Please circle): YES / NO
If yes please explain: _____

Is your child/adolescent currently experiencing difficulties with (please circle): eating patterns / sleeping patterns / chronic pain?
Please explain: _____

Is your child/adolescent currently experiencing (please circle): anxiety / panic attacks / phobias?
Please explain: _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial concerns, in the last 5 years?
If so, please explain: _____

What significant life changes or stressful events has your child/adolescent experienced recently? _____
_____

Has your child/adolescent ever had counselling before? (Please circle): YES / NO

Where did they receive counselling? _____

What was it concerning? _____

When did your child/adolescent go? _____

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General Information continued:

Does your child/adolescent consider themselves to be spiritual or religious? (Please circle): YES / NO
Please describe their faith and what this means to them: _____

Is your child/adolescent currently in treatment for any medical problems? (Please circle): YES / NO
Please explain: _____

Does your child/adolescent have significant medical problems? (Please circle): YES / NO
Please explain: _____

Has your child/adolescent had any serious illnesses, accidents, or surgeries in the past? (Please circle): YES / NO
Please explain: _____

Please list all medications currently prescribed: _____

Is there or has there been a concern about alcohol, drug abuse or overuse of non-prescribed drugs? (Please circle): YES / NO
Please explain: _____

Is there a history of psychiatric treatment or counseling? (Please circle): YES / NO
Please explain: _____

Is there any concern about suicide? (Please circle): YES / NO
Please explain: _____

How concerned are you about the possibility of suicide? On a scale of 1-10 (1 – not concerned, 10 – extremely concerned): _____

Does your child/adolescent have someone they can talk to about it? (Please circle): YES / NO
If yes who? _____

IF YOU EVER NEED TO TALK TO SOMEONE BEFORE YOUR APPOINTMENT
PLEASE CALL THE DISTRESS CENTRE AT **(905) 278-7055** OR VISIT THEIR WEBSITE **www.distresscentrepeel.com**

What would you like to accomplish as a result of your child/adolescents time in therapy? _____
_____

Is there anything else that you would want the Social Worker to know before your child/Adolescents appointment? (Please circle): YES / NO
Please explain: _____

Family History: Please check and indicate which family member

Illness	✔	Family member/s and age	Complications/Severity
Alcohol/Substance abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Disorder			
Schizophrenia			
Suicide Attempts			
Other			
Family history unknown			