OAKVILLE
WELLNESS CENTER

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Winnipeg Manitoba R3M 2L7
www.oakvillewellnesscenter.com
T:204.515.6433
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Therapist Candidate

Guardian Service Agreement for Therapy

Your therapy services are provided by a student (Therapist Candidate) from Providence Theological Seminary. As part of the training, the therapy services provided will be completed under the supervision of Dr. Syras Derksen C.Psych, who will oversee all of the practicum activities and is ultimately responsible for all therapy services provided by the practicum student (Therapist Candidate). At any time you may request to see Dr. Derksen by calling 204-201-0751.

Expectations: While there are no guaranteed outcomes in therapy, you can expect a safe environment that does not discriminate against age, sex, race, ethnic background, religion, disability, sexual orientation, or political affiliation. We strive to provide great treatment and, as part of providing the best service possible, you may receive email or phone contact(s) asking you about your experience. Unless otherwise indicated, your response will be shared with your therapist to help them improve their service to you. At any time, you may ask questions about your treatment, refuse to participate in specific tasks, or terminate services.

Confidentiality: The information you share is confidential. However, as a therapist candidate, to facilitate my educational growth and development as a therapist, I will regularly meet with my supervisor, Dr. Syras Derksen C.Psych.. During these meetings I will be discussing and reviewing the information shared. Dr. Derksen may also elect to join us in our sessions. Part of my supervision includes recording the sessions either by video or audio for review by my supervisor. If by video, the camera would be on me. The audio/video files will be encrypted. As my supervisor, Dr. Derksen will have access to all my client records and will be retaining these records at the completion of my internship. You may request a copy of your records at any time in writing to myself and/or my supervisor.

As a therapist candidate, I will also be completing case presentations in the context of my practicum class. In doing so, I may share information about you with my professor, teaching assistant, and fellow students. The purpose of these presentations is my own educational growth and development as a counsellor. If I share information about you in class, I will disguise and never disclose your identity.

As part of the Oakville Wellness Center team, I will be using approved software which is secure, encrypted. Oakville Wellness Center employs administrative help who may be exposed to private information. These staff persons are only given access to information on a need to know basis and are under agreements to keep information confidential.

Although your service here is confidential, there are exceptions to this confidentiality. These exceptions include:

- Child Welfare and Protection of Vulnerable Persons: We are required by law to report abuse or neglect of children and other vulnerable persons.
- Threats of Harm: If you do or say something that we believe puts the life or safety of yourself or another person at risk, we may ask for help from others to assist you.

- Justice System: If your file or therapist is subpoenaed by a court of law we are required to comply with this request.
- Contact Tracing: Please be aware that if your therapist becomes ill and the government requires "contact tracing" they will be required to comply. Contact tracing refers to the government requiring individuals who have contracted a disease to provide a list of all the people with whom they have come into contact within a determined time-frame.

Should you and your therapist meet in a social situation, your therapist will respect your privacy and not reveal the nature of our relationship. However, you should be aware that sometimes your own actions in a social situation might inadvertently breach your confidentiality. Should a social situation become ongoing, your therapist will discuss with you in private how to proceed to avoid any conflict of interests.

Therapist Availability: Should you require assistance outside of your appointment time, you may leave a message with the receptionist (204) 515-6433. If immediate assistance is required, consider calling the **Klinic Crisis Line (204) 786-8686**, the **Mobile Crisis Unit (204) 940-1781**, or going to the hospital.

Fees: As you are seeing a therapist candidate, there is a reduced rate for the sessions to cover administrative costs. As a student, I do not personally receive compensation for the counselling services that I provide to you. Sessions are 50 minutes in length. Phone calls, letters, and other consultations will be negotiated at the clinician's rate per 50 minutes. Short infrequent phone calls are included in this service. If you choose to meet with my supervisor at any time, his rate will be charged per 50 minute sessions.

Cancellation Policy: Please provide at least 48 hours notice if you would like to cancel or reschedule a session; otherwise you will be responsible for the cancellation fee, which is 50% of standard rates. Please note that insurance companies often do not reimburse cancellation fees.

Video-chat Sessions: Your therapist has access to an online platform which is both PHIA and PIPEDA compliant and we will endeavor to use this encrypted platform whenever possible. Moving forward, choosing to use alternate programs such as Skype, Google Hangouts, WhatsApp or similar platforms will imply informed consent to the inherent risks to confidentiality and security when using these systems.

Insurance Information: Services rendered by a therapist candidate may or may not be covered. It would be prudent to contact your insurance company to find out exactly what you are covered for. You will need to tell the insurance company my professional designation and you can find this by checking the website or calling our office. Some insurance companies require a medical referral. You are also responsible for submitting your receipts to your insurance provider.

It is our policy to conform with insurance regulations. Therefore, whomever is in the session must be listed on the receipt. It is up to you to verify with your provider what your coverage includes, how it pertains to you, your partner and children, and how the insurance company reimburses receipts with the relevant clients that will be listed on your receipt.

Oakville Wellness Center complies with Manitoba Justice's views on custody and provides service accordingly. Children under the age of 18 may require additional documents. In order to provide services to someone under the age of 18, these conditions must be met:

- Both biological parents must sign the guardian agreement

- If there is a separation or divorce, and one guardian states they have sole custody, primary care and control or joint custody and if both parents do not sign, a copy of the court ordered custody agreement must be provided in its entirety.
- If one parent is absent or unavailable please call the office at 204-515-6433

It is your responsibility to ensure you have read and understood this document.

Consent Summary: ***(please check all)***

- ☐ Sessions provided by a therapist candidate at a reduced rate.
- ☐ Sessions may be audio or video recorded for the purpose of supervision, guidance and growth as a therapist.
- ☐ Sessions will be discussed with my supervisor and case consults within the practicum class while maintaining confidentiality of identity.
- ☐ Sessions may or may not be covered by insurance.

√ I have been given the opportunity to ask whatever questions I may have had, and all such questions have been answered to my satisfaction.

√ I understand the information in this form and freely consent to begin therapy.

RESIDENCE:
With whom (both parent, one parent, other) does the child / adolescent / other reside?

_____

CUSTODY: (Proof of Custody is required)
Who (both parents, one parent, other) has legal custody of the child / adolescent / other?

_____

CONSENT:
I (We), _____, parent(s) / legal

guardian of _____ (print identified patient's name), freely consent to receiving therapy and / or assessment services.

Guardian (print/sign): _____/_____ Date: _____

Guardian (print/sign): _____/_____ Date: _____

Therapist Signature: _____ Date: _____