Today's Date: _____ (Y/M/D)

First Session: _____ (Y/M/D)

Therapist Name: _____

PPC Therapy Group
PROFESSIONAL PSYCHOLOGISTS & COUNSELLORS

1118 College Drive,
Saskatoon, SK S7N 0W2

Intake Form

Client Information

1) Legal Name (First/Last): _____ **Preferred**: _____ **DOB (Y/M/D):** _____

Phone Number: _____ ☐ **Yes, accepts voice messages.**

Email: _____ ☐ **Yes, accepts email correspondence.**

Address (include City & Postal): _____

2) Legal Name (First/Last): _____ **Preferred**: _____ **DOB (Y/M/D):** _____

Phone Number: _____ ☐ **Yes, accepts voice messages.**

Email: _____ ☐ **Yes, accepts email correspondence.**

Address: If different than indicated above (include City & Postal): _____

EMERGENCY CONTACTS (Relationship to client & Contact Numbers) - Provide 2 if possible:

Name: _____ Relationship to client: _____ Phone: _____

Name: _____ Relationship to client: _____ Phone: _____

What is the client's primary reason for attending? _____

Children Under 18

Under 18 years:

Guardian 1 Name: _____ Phone: _____

Guardian 2 Name: _____ Phone: _____

Under 15 years:

Child is being raised by both parents in the **same home (Y/N): _____**

Separated parents ***(must initial one):*** **Joint Custody: _____ Sole Custody: _____** (provide court order)

Court ordered **(Y/N): _____**

***Signature of BOTH parents is required* on the PPC Joint Custody Consent form before clients under 15 will be seen.**

PPC therapists offering counselling services to children will not be obliged to, nor will they provide support letters for parenting disputes, custody, or access.

Note

I understand that *some* services are covered by *some* EFAP's or insurance programs for *some* therapists.

I understand & confirm that:

- I am responsible for ensuring that the therapist(s) I see meet the criteria for my specific funder,
- I am responsible for covering all costs for each session and submitting claims myself when direct billing isn't available,
- Neither the Therapist nor PPC is responsible for denied claims or submissions.

Client's Signature: _____

Funding

☐ Employer/EFAP: _____

Employee name: _____ Relationship to Employee: _____

☐ Personally (or Self-Submit Insurance)

☐ Direct Billed Insurance (if available): Provider: _____

Plan/Policy: _____Certificate/Member: _____

Primary Plan Member Name, Date of Birth & Relationship: _____

☐ Other Funder: _____ Client # (If required):_____

☐ Other 3rd Party. Name & contact information of person(s) authorized to pay: _____

(This does not authorize the release of any session discussion. Only date, length & cost of sessions)

Who referred you to PPC or to your therapist? _____

Note below any other information you feel may be helpful to your therapist. Some examples might be strengths or qualities you admire about yourself, spiritual convictions, social, love, school/work, health/physical difficulties, etc.

This section is only required when directly billing to an Employee Family Assistance Program.

Note: The client we are seeing is not necessarily the employee, so **answers may or may not be the same for each question**.

What is the **client's** relationship to the eligible EFAP employee? _____

If the employee is also the client, is there a decline in job performance _____

Client's gender identity_____

Employee's gender identity_____ (if the employee is not the client)

Client's age_____

Employee's age_____ (if the employee is not the client)

Client's marital status_____

Employee's marital status_____ (if the employee is not the client)

Client's level of education_____

Employee's level of education_____ (if the employee is not the client)

Employee's type of employee (full, part, seasonal, casual) _____

Employee's status - Union (Local _____) Management Out of Scope

Client's occupation_____

Employee's Department/Division_____

Employee's length of service (in years) _____

Have you attended another counselling agency in the past 2 years and if so, which one?

_____

Agreement For Provision of Counselling Services Between:

The "Client": _____ and the "Therapist": _____

The Client agrees:

1. To provide 24 hours' notice when cancelling an appointment. ***Failure to provide proper notice may result in a missed appointment fee charged to you personally*.**
2. To pay any required fees each session, unless other arrangements are made.
3. To pay any fees declined by an EFAP or insurance provider.
4. If you subpoena your therapist or anyone at PPC, you will cover all associated costs. Costs for client rescheduling, report preparation or other such requirements will be **paid by the client** at an hourly rate determined by the therapist.
5. To not record any portion of the session without prior permission.

The Therapist agrees:

1. To provide counselling assistance based upon the Client's goals.
2. To maintain the confidentiality of the Client, unless:
   a) you may be a danger to yourself or others, or there is a reasonable suspicion of child abuse or neglect. You recognize in such circumstances that I have a legal and ethical responsibility to my professional association to notify the proper authorities.
   b) it is appropriate to consult with a professional colleague to improve the quality of my service to you; the information shared with this professional colleague will be kept anonymous and is restricted to the information necessary to aide in meeting your desired goals and to assist me in providing adequate service. This colleague will also be held to the rules of confidentiality.
   c) you initiate a legal action whereupon I may use information from my records to defend myself.
3. To not record any portion of the session without prior permission.

By signing this Agreement, I confirm that I have read, understand, and agree to the terms set out above. I also understand that my therapist is an Independent Contractor, not an employee or an agent of PPC, and is providing services to me directly and personally. I also agree that this contract between the Therapist listed above and myself. I also understand that my file will be destroyed within seven (7) years of my last visit.

Client's Signature: _____ Therapist's Signature: _____
(or authorized representative)

Date: _____ Date: _____

Intentionally blank

Intentionally blank

Telepsychology (Video or Telephone Sessions) Informed Consent

Telepsychology services use electronic communications (telephone, text, email, video conference, etc.). These sessions (tele-sessions) have some limitations compared to in-person counselling.

You understand that…

- You must be physically located in Saskatchewan if seeing a registered psychologist. Speak to your counsellor if you are outside of the province.
- Tele-sessions should occur in a private location using up-to-date technology and security measures.
- You agree that you are at least 18 years old. If you are a minor, a legal guardian must sign. If deemed a mature minor, a signature may not be required.
- Confidentiality applies to telepsychology services. No one may record, screenshot, or photograph any part of a session without permission. Be aware that confidentiality may still be affected during telepsychology.
- A technician may assist with equipment, and they will keep your information confidential.
- If the technology connection drops, you should have an additional device ready to contact your counsellor or have a plan for reconnection.
- The counsellor will assess the appropriateness of the technology used and may suggest alternative methods if necessary.

Emergencies and Confidentiality

At the start of each tele-session, your counsellor will need an emergency contact number and your location. If a session gets disconnected, and you feel in crisis, you agree to call 911 or your local emergency services immediately. If your counsellor is seriously concerned for your safety, they may need to break confidentiality and contact 911 or your emergency contact.

Limitations

Limitations may include, but are not limited to:

- **Miscommunication**: Without face-to-face interaction, misunderstandings may occur, affecting assessment.
- **Boundaries**: Texting and emailing can erode professional boundaries.
- **Time**: Unexpected delays may happen.
- **Technological Issues**: Equipment failures, message delivery problems, and security breaches can occur.
- **Crisis Management**: Verifying client and contact information may be limited.

Fees, Payment, and Cancellations

- Tele-session fees are the same as in-person sessions; however, insurance may not cover telecommunication services. Check with your insurance provider to confirm reimbursement.

Payment Options:

- **Credit Card**: Provide your credit card information to PPC reception. It will not be stored on file.
- **E-Transfer**: Send to office@peopleproblems.ca, including your name, counsellors name, and session date in the message.
- **Contact PPC**: Call (306) 664-0000.

Video and Telephone Cancellations follow the same policy as in-person sessions.

Telephone Sessions

Your counsellor will call from a mobile or landline phone. The number may or may not display. If the call is lost, your counsellor will attempt to call back immediately. They will try to reconnect.

Note: Telephone communication is not 100% confidential.

Video Sessions

You will receive a link to the video conferencing platform, which complies with HIPAA, GDPR, PHIPA/PIPEDA, and HITECH. If connection issues arise, the counsellor will use the provided phone number to reach you.

Email and Text Communication

Communication may occur via email or text for rescheduling or sharing resources. Please note:

- Significant messages will be added to your file.
- Email is not suitable for urgent or crisis concerns, as it is not 100% confidential.

Note: Email or Text communication is not 100% confidential.

Disconnection from Technology

If you cannot reach your counsellor, call PPC reception at (306) 664-0000 or the alternate number your counsellor provided. You can also report issues via email at office@peopleproblems.ca.

- If connection is lost and cannot be re-established, and if the counsellor believes you are in crisis, the emergency plan will be activated.

Consent to Participate in Telepsychology

By signing below, you agree that you have read (or have had read to you) all the previous sections of the Telepsychology informed consent addendum and that you understand the limitations associated with participating in Telepsychology and consent to attend tele-sessions under the terms described in this document. You also understand that the counsellor is an independent contractor, not an employee or an agent of PPC, and providing services to you directly and personally.

Telepsychology Safety Plan

1) Clients Name (First/Last): _____

2) Clients Name (First/Last): _____

Clients Phone Number: _____ Alternative Phone Number: _____

Physical address of client/s is required at the start of each tele-session.

Street: _____

City: _____ Postal Code: _____

Emergency Contact (1): _____ Relationship: _____

Phone Number: _____ Address: _____

Emergency Contact (2): _____ Relationship: _____

Phone Number: _____ Address: _____

Location of the nearest Hospital to the client: _____ Phone Number: _____

- I have provided two emergency contact numbers and the number to the local hospital or other facility as deemed appropriate.
- If there is an emergency during a tele-session, my counsellor has permission to contact my emergency contacts and/or emergency services.
- I have provided contact information to be reached at if the Telepsychology connection fails.
- If connections fail and my counsellor does not connect with me by the end of my tele-session, I will call PPC (306) 664-0000. If I am not able to speak to someone directly, I will leave a message or email office@peopleproblems.ca
- If I am unable to be re-connect with my counsellor or PPC and I am in crisis, I will contact 911, the local emergency room or local emergency services.

1) Clients printed name: _____

Signature: _____ **Date:** _____

2) Clients printed name: _____

Signature: _____ **Date:** _____

Counsellors printed name: _____

Signature: _____ **Date:** _____

Print and complete this page. Scan to email or mail to PPC office@peopleproblems.ca

Address: 1118 College Drive Saskatoon, SK S7N 0W2

Client Copy

Agreement For Provision of Counselling Services between:

The "Client": _____ and the "Therapist": _____

The Client agrees:

6. To provide 24 hours' notice when cancelling an appointment. ***Failure to provide proper notice may result in a missed appointment fee charged to you personally*.**
7. To pay any required fees each session, unless other arrangements are made.
8. To pay any fees declined by an EFAP or insurance provider.
9. If you subpoena your therapist or anyone at PPC, you will cover all associated costs. Costs for client rescheduling, report preparation or other such requirements will be **paid by the client** at an hourly rate determined by the therapist.
10. To not record any portion of the session without prior permission.

The Therapist agrees:

1. To provide counselling assistance based upon the Client's goals.
2. To maintain the confidentiality of the Client, unless:
   d) you may be a danger to yourself or others, or there is a reasonable suspicion of child abuse or neglect. You recognize in such circumstances that I have a legal and ethical responsibility to my professional association to notify the proper authorities.
   e) it is appropriate to consult with a professional colleague to improve the quality of my service to you; the information shared with this professional colleague will be kept anonymous and is restricted to the information necessary to aide in meeting your desired goals and to assist me in providing adequate service. This colleague will also be held to the rules of confidentiality.
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Client's Signature: _____ Therapist's Signature: _____
(or authorized representative)

Date: _____ Date: _____