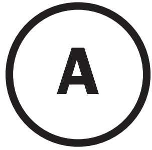
Consent for Service

A Client & Service Information
B Confidentiality & Privacy
C Limits of Confidentiality
D Authorization
E Cancellation Policy
F Terms of Payment Agreement



Client & Service Information

I, ____
(Print Full Name of Parent/Guardian)

hereby provide consent for (please select below)

- ☐ Audiology
- ☐ Massage Therapy
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Psychology & Social Work
- ☐ Speech-Language Pathology
- ☐ Other: ______________

to provide the following (please select below)

☐ Consultation ☐ Assessment ☐ Treatment

for ______________________________
Client's Name (Child's Name)

Date of Birth: ______ / ______ / ______
(Day) (Month) (Year)

I agree that I have received information and had the opportunity to ask questions regarding: the nature of the service; the expected benefits of the service; the material risks of the service; the material side effects of the service; any alternative courses of action; the likely consequences of not having the service or of discontinuing the service.

Confidentiality & Privacy

I am aware that a health record was created for the client and all records are confidential.

Regardless of how many professionals are directly involved with the client, I am aware and consent to professionals within and across disciplines at Boomerang Health to informally consult each other in order to best serve the client.

I understand that Boomerang Health will not share any information about the client to outside parties (e.g. school, physicians, community programs) without my written consent (see Consent to Obtain/Release Information Form). Boomerang Health's privacy policy is posted on the website.

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I am aware that a health record may include various types of information about the client, including session summaries, email and phone communication. With respect to information submitted via electronic means (ie., email) I am aware of the potential limits to confidentiality associated with this form of communication. Although we will do our best to encrypt information shared when possible (e.g., when sending psychological reports) electronic communication may not be completely private or secure. The risks may include, but are not limited to the following:

- Employers and online services may have a legal right to inspect emails that pass through their system; email is easier to falsify than hand written or signed hard copies; email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the sender and recipients; email senders can easily misaddress an email resulting in it being sent to many unitended or unknown recipients; email is indelible. Even when deleted by both sender and recipient, back-up copies may exist on a computer or cyberspace.

Please note that the clinician is not responsible for breach of confidentiality and for information loss due to technical failures associated with the client's email software or internet service provider. Please avoid using an employer's or third party's computer and take reasonable precautions to preserve confidentiality.

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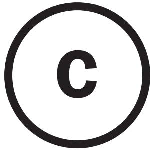
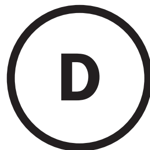


Limits of Confidentiality

I am aware there are four situations where healthcare practitioners (HCP's) are obligated, either legally or ethically, to share information:

- When there is concern a child is being harmed or is at risk of being harmed. This may include actual or suspected physical, emotional, or sexual abuse, neglect, or a pattern of failure to follow through on necessary treatment. The HCP is required to contact the Children's Aid Society (CAS).
- When Boomerang Health staff and/or documentation are "subject to subpoena" by the court (that is, when they are requested by a judge for a legal proceeding in family or criminal court).
- If someone presents an imminent danger to him or herself, or to others (e.g. if a client or parent is considered suicidal or homicidal).
- If it is reported that a member of another regulated healthcare practitioner has been sexually inappropriate. In this case, a report will be made to the practitioner's college. Your name or the client's name will not be reported without your explicit consent.
- If it has been reported that there has been abuse or neglect of a resident living in a long-term care facility or retirement home.



Authorization

I confirm that I am authorized to give consent on behalf of the client. I am aware that Boomerang Health will not intervene into any family conflicts related to custody, divorce, separation or legal guardianship. I am responsible for notifying Boomerang Health about any such conflicts if they arise. In the event of a conflict, Boomerang Health may suspend or cease providing services until such time that such conflict is resolved, and authorization to consent for treatment is clear. I am aware that Boomerang Health has the right to terminate or refuse services, for professional or legal reasons, to be determined at their sole discretion.

I am aware that I can withdraw from services at any time.

Signature of Parent/Guardian: ______________________________

Signature of Client (Child): ______________________________
(As Appropriate/12 Years or Older)

Relationship to Client: ______________________ Date: ______________

Cancellation Policy

Boomerang Health requires 24 hours' notice of appointment cancellations. If less than 24 hour notice is given, there will be a charge equal to 50% of your appointment cost.

I, ______________________________ , agree to the cancellation policy as outlined above and agree to pay the 50% fee for appointments that are not cancelled at least 24 hours in advance.

Signature: ______________________ Date: ______________

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Terms of Payment Agreement

I, ______________________________, acknowledge and accept full and complete responsibility for
(Parent/Guardian/Client)

prompt payment for all service rendered to ______________________________ by Boomerang Health.
(Client)

I understand that all services from Boomerang Health are charged to me directly and that I am personally responsible for payment in full at the time of service. Boomerang Health will not submit invoices to health insurance companies.

Signature of Parent/Guardian: ______________________________ Date: ______________

Relationship to Client (Child): ______________________________