Consent for Service *(Caregiver/Guardian and Client)*

A Client & Service Information
B Confidentiality & Privacy
C Limits of Confidentiality
D Authorization
E Cancellation Policy
F Terms of Payment Agreement
G Tele-Rehabilitation and Medical Services

A Client & Service Information

I, _____

(Print Full Name of Caregiver/Guardian)

hereby provide consent for

_____ Date of Birth ____ ____ ____

Client's Name (Child's Name) *Month* *Day* *Year*

to receive the following service(s) *(please select below):*

- ☐ Massage Therapy
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Psychology
- ☐ Social Work
- ☐ Speech Therapy
- ☐ Other: _____

and to receive consultation, assessment, and/or treatment related to the above service(s).

Relationship to Client (Child): _____

☐ 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.

Signature of Caregiver/Guardian _____ Date ____ ____ ____
Month *Day* *Year*

Signature of Client (*Child*) _____ Date ____ ____ ____
As Appropriate/12 Years or Older *Month* *Day* *Year*

B 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. Further, I am aware that administrative staff will have access to the file for the purposes of coordinating care, scheduling, billing and client safety.

☐ 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 (i.e., email) I am aware of the potential limits to confidentiality associated with this form of communication. Although the clinic will do their best to encrypt information shared when possible (i.e., 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 agencies that support electronic medical records and communication may have a legal right to inspect e-mails that pass through their system; email is easier to falsify than hand written or signed hard copies; e-mail 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 e-mail resulting in it being sent to many unintended or unknown recipients; email is indelible. Even when deleted by both sender and recipient, back-up copies may be 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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C

Limits of Confidentiality

☐ I am aware there are five situations where healthcare practitioners (HCP's) are obliged, 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) or equivalent agency.
- 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 themselves, or to others (i.e. if a client or caregiver 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.

D

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.

E

Cancellation Policy

Boomerang Health requires 24 hours' notice of appointment cancellations. If less than 24-hours' notice is given, for rehabilitation services there will be a charge equal to 50% of your appointment cost, and for physician services there will be a flat fee of $50.00 CAD.

☐ I agree to the cancellation policy as outlined above and agree to pay the fees for appointments that are not cancelled at least 24 hours in advance.

F

Terms of Payment Agreement

☐ If applicable (i.e. rehabilitation services, uninsured physician services) I acknowledge and accept full and complete responsibility for prompt payment for all services rendered to the client by Boomerang Health.

☐ I understand that all services with applicable fees (i.e. rehabilitation services, uninsured physician 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 on my behalf.

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G

Tele-Rehabilitation and Medical Services

☐ I am aware that tele-rehabilitation and medical services are being offered, as appropriate. There is an increased security risk that health information may be intercepted or disclosed to third parties when using video or audio communications tools. By agreeing to tele-rehabilitation, you are agreeing to the following: That video, emails, or calls that you may receive are not secure in the same way as a private appointment in an exam room. By providing your information, you agree to let us collect, use, or their personal health information through video or audio communications (while following applicable privacy laws) in order to provide you with care. In particular, the following means of communication may be used: telephone calls, email, and videoconferencing (i.e., Zoom). We have taken reasonable steps to reduce the risks and protect your privacy as much as possible. For example, we will conduct tele-rehabilitation sessions in a private room where no one can watch or listen. Please make sure to use a private space for your sessions as well.

☐ I understand the information that I have received and had the opportunity to ask questions regarding the sections in this document listed as:

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Signature of Caregiver/Guardian _____ Date ____ ____ ____
Month *Day* *Year*

Signature of Client (*Child*) _____ Date ____ ____ ____
As Appropriate/12 Years or Older *Month* *Day* *Year*