ADVANCED COGNITIVE COMMUNICATION REHAB

General Consent Form

I,_____acknowledge that Rachel Dubé of Advanced Cognitive Communication Rehab has discussed the purpose and nature of the assessment/treatment to be administrated.

Please write your initial beside the following statements:

_____ I understand that Advanced Cognitive Communication Rehab is assisting me with my rehabilitation needs. The therapist has clearly advised me that another therapist can provide this intervention if I so choose without incurring any consequences. Either party may terminate this agreement at any time without incurring any consequences. Any services previously rendered will be payable immediately. All provisions of the Agreement which by their nature should survive termination shall survive termination, including, without limitation, ownership provisions, warranty disclaimers, indemnity, and limitations of liability.

_____ The therapist has explained to me that I may choose to accept or deny participation in assessment or treatment process.

_____ Consent to Teletherapy:
I understand that teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services via teletherapy over a secure video conferencing platform and other communication and electronic tools. I understand that the laws that protect privacy and the confidentiality of my medical information also apply to teletherapy. I understand that there are potential risks involving technology, including but not limited to: internet interruptions, and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that we are not responsible for any technical problems and do not guarantee that services will be available or work as expected. I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my username(s) and password(s) and not sharing these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear your conversation. I understand that either myself or my Speech-Language Pathologist can discontinue the teletherapy services if it is felt that this type of service delivery does not benefit my needs or for any other reason. I have read and understand the information provided above regarding teletherapy, have discussed it with my Speech-Language Pathologist and all questions have been answered to my satisfaction. I hereby give your informed consent for the use of teletherapy.

_____ I understand that Advanced Cognitive Communication Rehab is complying with the Privacy Legislation. If desired, I understand that I will be provided with opportunity to review their policy and ask questions as needed. I permit Advanced Cognitive Communication Rehab Clinic to collect, use, and disclose personal information about me as set out in their Privacy Policy.

_____ I understand that my live video call sessions with my Speech-Language Pathologist may involve recording both the audio and video of the video call session for further analysis. Your Speech-Language Pathologist will first ask permission to do this. These files will not be made public or used for marketing or promotional materials.

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_____ We will take all steps reasonably necessary to ensure that your data is treated securely and in accordance with this Privacy Policy and no transfer of your Personal Data will take place to an organization or a country unless there are adequate controls in place including the security of your data and other personal information.

_____ The therapist has explained to me the existence of the College of Audiologists and Speech Language Pathologists of Ontario.

Client's Signature:_____ Date (MM/DD/YYYY): _____

Address: _____

_____

Phone Number: _____

Date of Birth (MM/DD/YYYY): _____

Therapist's Signature:_____ Date (MM/DD/YYYY): _____