

TIME TO TALK – SOCIAL WORK Participation Agreement

PCN Wellness Centre
4000, 1800 - 194 Avenue S.E. Calgary, AB T2X 0R3
Phone: 403.668.8600 Fax: 403.668.8610



Welcome to Social Work Services through the Time to Talk (T2T) Program at the PCN Wellness Centre. This document outlines our expectations for your participation in our program.

As health providers, we receive referrals directly from your physician and our services are covered by Alberta Health Care.

We provide social work support, counselling and resources for clients who may be experiencing depression, anxiety, relationship conflict, stress and other mental health related issues.

Social Work sessions are 30 minutes long and we will meet for up to six sessions in total. For our sessions to be most successful, you will have to work on things that we talk about both during our sessions and at home.

As a registered Social Worker, I am governed by the Alberta College of Social Workers. I abide by the Health Professions Act and adhere to the Code of Ethics and Standards of Practice of my regulatory bodies.

Your health record

Records are created and maintained by your referring physician clinic under the name of the individual (client) referred. The same applies for couples and families involved in therapy.

Confidentiality

Patient information is treated with the highest standard of confidentiality. It is used to facilitate the social work process and maintain accurate records. Information you provide is collected, used and disclosed in accordance with the Health Information Act of Alberta. We will not seek patient information from, or provide it to, any other person or organization without your written consent, except where required by law. Where a patient is a minor or dependant adult, the guardian has the right to impose a limit on the patient's right to confidentiality. Access requests for couple or family records will be handled on a case by case basis by the referring physician's clinic.

Legislation permits the disclosure of your health information, without your expressed consent for purposes such as providing or continuing health services, mitigating risk of harm to yourself or to another person, if the disclosure is authorized by another Act or if the information relates to an offense or an investigation of a possible offense. Your health record can also be subpoenaed for court purposes. In order to provide you with quality care we may share your information with Alberta Health Services in order to connect you with ongoing services.

Clinical Supervision/Team Collaboration

To ensure that we can continue to grow as professionals, we work collaboratively with our team and on occasion our clinical work is supervised. This might take the form of case discussions and/or a reflecting team where your session is observed by one or more therapists. We believe that it can be useful to have more than one perspective and this service is designed to enhance your therapy experience. These discussions are bound by our standards of confidentiality. You have the right to refuse observation of your session.

Patient Feedback

We invite and value your feedback on our work with you. At the beginning of each visit you will be asked to rate your sense of well-being since your previous visit and to evaluate your experience of the session with your therapist at the end of each visit. Your opinion assists us in refining our approach so we can support you in maximizing the benefit from each session in T2T.

Out of Scope

We are not able to provide 3rd party assessments, psychological testing, psychiatric medication consultations, custody evaluations, readiness/return to work reporting, parenting assessments or developmental assessments.

Contacting Us

If you have any questions, please contact you family doctor’s office

Should you need confidential after hours assistance, please call the Distress Centre 24 hours a day at 403- 266-4357 (HELP).

I acknowledge that I have read and understood the above information and I consent to services/treatment with the Time 2 Talk Program. I also understand that I can withdraw this consent at any time.

Name: _____

Signature: _____

Witness name: _____

Witness Signature: _____

Date: _____