TIME TO TALK
Participation Agreement

Welcome to Time to Talk (T2T) Program. This document outlines our expectations for your participation in our program.

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

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

Counselling sessions are 50 minutes long and we will meet for up to six sessions in total. For counselling to be most successful, you will have to work on things that we talk about both during our sessions and at home.

All T2T Clinicians are accountable to their respective professions through the College of Alberta Psychologists and to the Alberta College of Social Workers. They abide by the Health Professions Act and adhere to the Code of Ethics and Standards of Practice of their 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 counselling 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 understand the above information and I consent to services/treatment with the Time to Talk (T2T) Program.

I also understand that I can withdraw this consent at any time.

Name: _____ PHN:_____

Signature: _____ DOB:_____

Witness Name: _____

Witness Signature:_____

Date: _____

❒ By signing this, I attest that I am the legal guardian for _____ (Child's name)