Lesley Ritchie, Ph.D., C.Psych, ABPP-CN
Clinical Neuropsychology & Rehabilitation Service

Clinical Services Agreement and Consent Form

Welcome. This document contains important information about my professional services and business policies. Please understand that not all of the services described in this document may apply to you and the services that I have agreed to provide to you/your family. Details regarding the Personal Information Protection and Electronic Documents Act (PIPEDA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of all personal data, including personal health information (PHI), is available at https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/ . The law requires an individual's consent for the collection, use, or disclosure of personal health information.

If you have any questions or concerns, please feel free to discuss them with me.

SERVICES OFFERED

I will provide services specifically designed to help you (and/or your minor child), or otherwise provide you with referrals to other professionals. My clinical services consist primarily of individual assessments (neuropsychological, psychological, psychoeducational and evaluations) and short-term consultations with individuals, parents/ significant others, educators, teams and other organizations, and related professionals. I also provide short-term psychotherapeutic intervention to adults for issues related to depression, anxiety, somatic distress, adjustment to illness or injury, and other related conditions.

APPOINTMENTS

Except for rare emergencies, I will see you (or your child) at the time scheduled. I understand that circumstances (such as an illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, I ask that you speak to me or my assistant directly and give me as much notice as possible to cancel or reschedule. This will allow me to offer your time to another person.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Psychological services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide me with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Manitoba, Ontario and Federal law and my professional codes of conduct/ethics. Some situations in which I may have an obligation to reveal information without your consent include:

- Should you give information regarding child(ren) at risk of abuse (I am required to inform the appropriate agencies)
- Risk of suicide or serious harm to others (I must take appropriate measures to prevent this, e.g., notify police)
- A subpoena by the court (in the case of legal proceedings)
- Professional quality assurance evaluations (by outside regulatory bodies)
- COVID-19 contact tracing

As well, should an assessment show that your cognitive abilities are impaired to the degree that your driving may be impaired, this will be mentioned in the report, which gets sent to the referring physician.

RECORDS. I will review all testing results with you. I will forward copies of any reports or written summaries to others only with specific, written consent from you, though copies of the reports are routinely sent to

referring physicians (unless you expressly ask me not to do so). Because of the proprietary nature of testing materials, I will release raw testing data only to other appropriately credentialed professionals (except as otherwise required by law).

ELECTRONIC AND SOCIAL MEDIA. During our initial phone conversation(s), I requested your permission to leave voice mail messages at the phone number(s) you provided to me, and to correspond by email. If you granted your consent, note that it can be revoked by you at any time. Note, too, that I take reasonable precautions to safeguard the confidentiality of my electronic records and communications and secure fax, but I cannot guarantee it with absolute certainty. I do not communicate with clients via text messaging or accept requests for social media connections (e.g., LinkedIn, Facebook) for privacy reasons. If you have any questions or concerns about the security of our electronic communication(s) or the transmission of confidential information by electronic means at any time, please share them with me.

WORK WITH MINOR CHILDREN

If a client is under eighteen (18) years of age, the law may provide parents with the right to examine the minor child's records. Privacy, however, is often crucial to successful progress in treatment and valid evaluation results. If, in the course of an evaluation or consultation, a minor child reveals to me information that he or she does not want shared with his or her parents or guardian, I usually do not reveal such information unless I believe that there is a high risk that the minor will seriously harm him/herself or others, and in which case I will notify him or her of my intent to notify his/her parents or legal guardian(s).

PREPARATION FOR TESTING

It is important that individuals be able to perform at their best during testing sessions. Please let me know *before you arrive* (and as soon as possible), if the individual to be tested is not feeling well (except in case of concussions, when symptoms are expected), or is taking any prescribed or over-the-counter medications that I have *not* been told of in advance. In such cases (including leaving necessary prescription eyeglasses at home), the testing session may need to be rescheduled. If we have agreed that the individual to be tested should take regularly prescribed medications prior to testing and they did not do so, we may need to reschedule that session, and you may be charged for a missed appointment if we are not able to complete testing that day as scheduled. Individuals to be tested should be well rested and should bring snacks for breaks during the testing session. Parents should plan to remain in the office during all appointments with their minor children unless other (previous) arrangements have been specifically discussed with me.

SHARING TESTING INFORMATION. For comprehensive evaluations, I will review all testing results during our feedback session. Except in cases of independent assessment (i.e., an assessment completed solely for a third party wherein feedback is not provided to the patient), clients will be provided with a written summary of assessment results and the associated recommendations. Written documentation is typically forwarded by mail following a feedback session.

Because of the proprietary nature of testing materials, I will release raw testing data only to other appropriately credentialed professionals (i.e., clinical neuropsychologist or clinical psychologist in some cases) except as otherwise required by law.

PATIENT RIGHTS

PIPEDA provides you with several rights with regard to my clients' *Clinical Record* and disclosures of protected health information. These rights include requesting that I amend the record (this does not include the removal of diagnoses or recommendations); requesting restrictions on what information from the *Clinical Record* is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

CONTACTING ME

Given my many professional commitments, I am often not immediately available by telephone. If you need to leave me a message, I will make every effort to return your call promptly (within 1-2 business days). If you are difficult to reach, please leave some times when you will be available. Because of the short-term nature of the services I usually provide, I do not provide on-call coverage 24 hours per day, 7 days per week, exchange text messages with clients, or regularly check/respond to emails outside of standard business hours Monday through Friday. In emergency or crisis situations, please contact your physician, or call 911 and/or go to the nearest hospital emergency room.

CONSENT

Your signature(s) on next page indicates:

- you have read the information in this document and agree to abide by its terms;
- you have made every reasonable effort to provide me with complete, true, and accurate information as requested, including but not limited to information regarding any/all previous testing and current/anticipated involvement in related litigation;
- you understand that false, inaccurate, or incomplete information may invalidate any services provided; and
- you are legally authorized to provide consent for the services requested. In cases of separation or divorce, consent by all parents/legal guardians (those with legal custody) may be required; if it is required by law, your signature indicates that you have provided me with the contact information for any other party(ies) required to provide consent, if you have not already obtained that signature for me, and notified me in advance so that I can obtain that consent prior to our scheduled appointment.

For services for minor children: child's signature below indicates that you have discussed the anticipated services with him or her. I will also discuss with your child the services to be provided on the (first) day of service. A parent or legal guardian should accompany minor children to each appointment and remain in the office, unless alternate arrangements have been discussed with me in advance.

If any client is no longer a minor, but is dependent upon another party (such as parents/guardians) for payment of services, signatures of all involved parties will be required below (though a signed release of information will be required in order to exchange any additional information with parents if the child is no longer a minor).

_____	_____
Client or Child's name	Date
_____	_____
Client or Parent/Guardian #1 name	Parent/Guardian #2 name
_____	_____
Client or Parent/Guardian #1 signature	Parent/Guardian #2 signature

My parent(s) (or legal guardian(s)) have discussed with me the purpose of my testing or other work with Dr. Ritchie. I understand that Dr. Ritchie will be working with me in order to help me at home and/or at school.

I agree to answer Dr. Ritchie questions honestly, but I do not have to answer all of her questions if I am not comfortable sharing certain information with her.

Dr. Ritchie has told me that my parents have agreed that she does not have to tell them everything that I say to her if there is anything that I would like to remain private, unless there is a high risk that I will seriously hurt myself or someone else, or someone has caused serious harm to me. In this particular case, Dr. Ritchie will tell me if the information must be shared with my parent(s) (or legal guardian(s)) or others.

_____ _____

Child's signature Date