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| **CONSENT TO PARTICIPATE IN SERVICE**  I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  p (client, substitute decision maker in print) (myself or clients name),    of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (address) (phone number)  give my consent to participate in all Occupational Therapy and Physiotherapy Services (assessment, intervention, consultation) provided by Simcoe Habilitation Services Inc (SHS) as indicated on the consultation request / referral.  Should there be a change in the clients status, I consent for service in any of the areas listed on the consultation request except for (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***I acknowledge the following with my initial on the line:***  I understand that I can contact the therapist at any time to discuss the service and review my file. \_\_\_\_  I understand that I will be informed about fees and costs that might arise prior to them occurring. \_\_\_\_ I give permission to obtain photos of the client for sole use to support documentation of complex set up.\_\_\_\_  This consent is in effect as long as the client named above is receiving services from SHS OR until I inform SHS that I am withdrawing my consent.\_\_\_\_  I generally agree that the client named above participates in the provision of service through secure videoconferencing (tele-health). I understand that tele-health sessions are scheduled in advance and agree that the consent for each specific session will be confirmed by the client or a care giver present. \_\_\_\_\_  My signature confirms my consent:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (signature) **Date consent given** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If signature is not that of client, specify relationship and contact details (address, phone number) .* |

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| **CONSENT FOR COLLECTING, USING AND RELEASING CLIENT INFORMATION**  I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (client, substitute decision maker in print) (myself or clients name),  give my consent that Simcoe Habilitation Services Inc. will collect , use and disclose clients personal health information that is required to provide the service indicated on the request for consultation.  I understand that this information will be communicated and stored on paper and electronically including email communication. It will be used and updated with others involved in the care of the client named above. These parties can include  - ADP ( Assistive Device Program) **-** ADP authorized equipment vendor  - ODSP (Ontario Disability and Support Program) - NIHB (Non-Insured Health Benefits)  - Community service agencies - Funding agencies (e.g. Ontario works, march of dime, ….)  **- Health care provider (e.g. physician, speech and language pathologist, podiatrist, dietician, nurses )** This consent is in effect as long as the client named above is receiving services from SHS OR until I inform SHS that I am withdrawing my consent.\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of client or legal guardian or POA (Date given)**  *If signature is not that of client, specify relationship* |

SIMCOE HABILITATION SERVICES *256 Hughes Road, Office A  
 Orillia, Ontario, L3V 2M4*

**PHYSIO AND OCCUPATIONAL THERAPY SERVICES SINCE 1979**  *P. 705-325-8622, F. 705-259-8566*

