Restorative Wellness Project

Phone: (250) 619-0901 or (343) 364-9155
Email Completed form to: intake@restwp.com

Confidential Intake Form

General Information

Group Participant Name: _____ /_____
(First) (Last)

Date of Birth: _____ /_____ /_____ Personal Pronouns: _____
(Month) (Day) (Year)

Address: _____
(Street Number, Street Name)

_____ /_____ /_____
(City) (Province) (Postal Code)

Phone Number: _____ Email Address: _____

Personal Health Number: _____ Status Number (if applicable): _____

How were you referred to services?

_____

Funding/Payment

1. Do you identify as First Nations, Métis or Inuit? ☐ Yes ☐ No
2. Do you have extended benefits through work for counselling? ☐ Yes ☐ No

We ask you for permission to update your physician or psychiatrist with your progress

Initial: _____

Physician/psychiatrist name: _____

Any other helpers you'd like us to connect with? _____

Group(s) you are interested in taking?

☐ Dialectical Behavior Therapy Skills (4 modules; 4 weeks each module)
☐ Mindful Self Compassion MSC (8 weeks)
☐ Mindfulness-Based Relapse Prevention Group (8 weeks)
☐ 16 Steps to Recovery Group (~18 weeks)
☐ I want to add 1:1 counselling alongside my group sessions

Group Limits to Confidentiality:

1. If you have been referred by the court, your medical doctor, or another agency, these referrals may wish to receive a report or evaluation. In order to meet this request, a "consent to release information" form must be completed by you. Please notify us if there are any release forms that need to be completed prior to commencing therapy.

2. If we have a reason to believe that there is any type of child abuse, or neglect of a vulnerable person occurring, we are obligated by law to report this to the appropriate government agency.

3. If there appears to be imminent risk of harm to either yourself (self-harm, suicide) or others (violence, homicide), we are obligated to report this to the appropriate authorities.

If you have any questions regarding confidentiality, please. discuss them with the person who referred you to services.

I acknowledge that I have read and fully understand the limits of confidentiality.

Initial: _____

Please Note….

Not all insurance plans cover our services. Please check with your EAP provider and our office before assuming you have third party coverage. Plans may cover a Registered Clinical Counsellor (RCC) and/or Registered Social Worker (RSW). If there are limits to coverage, please contact us. Please communicate with your group facilitator regarding payment rates and time/date options.

Payments are to be made prior to each session via e-transfer to **payments@restwp.com**

Initial: _____

Participation Agreement for 1:1 Sessions

1. Clients who will be late or will be missing a session are expected to communicate this to their support directly with minimum 24 hours notice. Late cancellations or "no shows" will result in billing of your full session fee.

Initial: _____

Participation Agreement for Groups

1. Clients who will be late or will be missing a session are expected to leave a message (text or email) to the facilitators before group. If there is no notification, clients will be marked as a "no show".

2. Clients are considered to have dropped out of the group if they have missed 2 consecutive sessions without a notified absence, or if a total of 3 sessions in one module are missed without a valid medical or emergency reason.

3. Clients agree to review the lesson material at home, complete assigned home practice, including the daily diary card (on app) and other homework sheets prior to the next session.

4. Clients agree to not come to the session under the influence of drugs or alcohol (doing so will result in being asked to leave the session). This is not punitive, but we want everyone to be in learning mode as there is a lot of material. We are also mindful of collective safety of the space we create in groups.

5. Clients agree to keep information shared in session, as well as the names of other individuals in the group confidential. Clients also agree to preserve privacy if encountering another group member in the community.

6. Clients agree not to discuss past or present suicidal ideas/behavior with other clients outside of the group sessions.

7. If you choose to participate in the ORS and SRS data collection, you are comfortable with RWP using this data in its anonymous form. Facilitators discuss the parameters and use of the ORS and SRS regularly throughout modules, and the data will always be available to you as you'd like. Please ask your facilitators any questions as they come up.

8. Clients agree if a relationship is formed outside of group, it must be acknowledged. It is unacceptable for any member to demand another member to keep a secret, problem, or mental health emergency from the group. If outside relationships become problematic, clients may be asked to leave until a later time. Sexual partners may not be in skills training together. One partner would be asked to take the training at another time (unless a long-term couple requests consideration to attend together ahead of registration).

9. Clients agree that it is their responsibility to access crisis resources if they feel at risk. To access the crisis line call 1-888-494-3888. There is a walk in Crisis Counselling (free) at Brooks Landing Mall in Nanaimo, and the Psychiatric Emergency Services Department at NRGH for emergencies.

Wellness Together Canada is a free, government-run counselling service available 24/7: https://wellnesstogether.ca/en-CA

DO NOT contact the facilitators between groups for emergencies. Email and text are solely reserved for appointment booking and relaying late or missed classes.

_____ _____

Participant Name **Participant Signature**

**Written name accepted in lieu of signature if there is difficulty signing

_____

Date

_____ _____

Emergency Contact Name **Emergency Contact Phone Number**

Zoom and Microsoft Teams Safeguards and Security

We use both Zoom Pro and Microsoft Teams to facilitate groups and individual sessions. These platforms have advanced safety features to ensure the upmost privacy and security. Zoom and Microsoft Teams sessions are password protected, feature a waiting room to prevent un-invited guests, and are locked after participants are admitted, avoiding interruption from non-participants. Microsoft Teams requires two-step authentication and offers data encryption during transit and at rest.

To keep the safeguards protected, it is important that you do not share the meeting passwords or information with others. Additionally, facilitators and participants should be cognizant of security, ensuring that you are in a private space where you will not be overheard by others. It is strongly recommended that you do not join a session while driving due for your safety.

- Updated May 2021

Photo, Audio and Video Consent

This is completed along with verbal discussion with RWP team members

For all group participants, team members and special guests:

We request your permission to record the group therapy sessions that you participate in and want you to know that your privacy and identifying information will be strictly held in confidence.

We record groups for three reasons:

1. If you or any enrolled group participants miss a session, the recording is available for the duration of the module plus 7 days through a link before it is taken offline and made unavailable. Recordings can also be used for reminders and during breaks between modules. **Occasionally, it may be the case that an active participant has limited access to infrastructure to allow for streaming of links. In these rare cases, a participant may be given an audio file with option to download. These folks will sign a separate agreement outlining their agreement to keep the audio file (no images attached) in confidence and agree that they will not distribute or share it in any way.*

2. RWP keeps digital and written record of Elders, Cultural Teachers and Holders of Traditional Wisdom that sit in our groups to offer culturally and spiritually enhanced content. Once the viewable link expires, your group session will be saved in our secure drive until it is edited to remove all video that has your image, voice or identifying info in it. What we keep is the teachings of the Elders and the Group Facilitators to create an online culturally enriched group offering for remote locations or online learning.

3. For future qualitative research: this authorization grants permission to use your spoken words (transcribed) to share any deep or profound insights you have as a quote (e.g. “one participant said…”) for our research and for developing the cultural enhancement of Mental Health Services offered through Restorative Counselling, Restorative Wellness Project (RWP) or Restorative Health Network.

Additionally, Restorative Counselling and RWP have begun research to better track the outcomes of participants wellness (ORS and SRS scales). Participants will need to consent that FIT-Outcomes may record the data from strictly a research perspective. The information that RWP will collect is name (only initials will be used in the program), and email address, so that RWP team members can send participants the scales that need to be collected for research.

If you are receiving services from a graduate student, they will be recording all of their 1:1 sessions. These recording are used for learning purposes and may be displayed to their faculty instructor and colleagues. Do you consent to them utilizing recorded sessions for learning and academic purposes?

☐ Yes ☐ No

By signing this document, you agree:

1. To allow the recording of your image and voice (photographs, audio, or video)

Initial: _____

2. To distribute your image or recording to appropriate recipients (others in group or RWP professionals)

Initial: _____

3. To grant permission to other entities to reproduce the above content while preserving your privacy and anonymity, for educational purposes

Initial: _____

4. To allow RWP to collect and research data that will enable RWP to complete better and more thorough services to participants, while preserving your privacy and anonymity

Initial: _____

5. Consenting to the use of Microsoft Teams and Zoom for use of counselling sessions

Initial: _____

6. Understanding that completion of the Outcome and Session Rating Scales (ORS/SRS) and other assessment tools are an important part of care and to participate to the best of your ability

Initial: _____

Lastly, is there anything we can do to make groups or services more accessible for you? (Disabilities, needs, etc.)

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

PAY PROVIDER AUTHORIZATION

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

PROVIDERS — Before a provider requests that Pacific Blue Cross directly pay the provider for product(s) and/or service(s) provided, or to be provided to the patient, the provider must have the patient first sign the below authorization. This form shall be signed by each patient before any request for a direct payment is made.

The form must be kept on file for a minimum of three (3) years from the last date of claim submission on the patient's behalf.
If Pacific Blue Cross requests a copy of this document, the provider has 21 business days to surrender this document.

PART 1 — PROVIDER INFORMATION

Provider name	Pacific Blue Cross Provider number
Danielle Berube-BCRS14729/Josh Drummond-BCSW15996/Kristen Berube-BCCC10501	Megan Gasparotto -T15699-all RWP clinicians

PART 2 — MEMBER INFORMATION

Policy number	ID number/Status number	Name of plan, company name or Plan sponsor (if applicable)

First name	Last name

PART 3 — PATIENT INFORMATION

Patient's first name	Patient's last name	Patient's birthdate (mm-dd-yyyy)	

Street address	City	Province	Postal code

Relationship to Plan member: ☐ Self ☐ Spouse ☐ Child

This section only

PART 4 — PATIENT CONSENT AND DECLARATION

I, the patient, authorize the above named provider to direct bill Pacific Blue Cross (PBC) on my behalf for product(s) and/or service(s) provided to me or my dependent(s).

I consent to the collection, use and disclosure of my personal information and that of my dependent(s) for the purposes of PBC, including determining benefits eligibility and coverage, administering my benefits plan, and carrying out the purposes outlined in PBC's privacy policy. I consent to PBC collecting, using and exchanging personal information about me and my eligible dependents with any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I consent to the disclosure of my personal information by PBC to my plan sponsor, when required or permitted by law or pursuant to its contractual obligations under my benefit plan.

I consent to the collection, use, and disclosure of my personal information and that of my dependent(s) for the purposes of PBC conducting inquiries or investigations to verify claims, to ensure that my provider is submitting claims in accordance with PBC's requirements, and that the claims submitted on my behalf are accurate including the actual product(s) or service(s) delivered, the benefit(s) the service(s) is billed to, who received treatment, and the quantity of product(s) or service(s) delivered.

I further agree that I am to use my best efforts to verify all claims submitted by my provider on my behalf by monitoring my claim statements received via the on line Member Profile or mailed to me; and will notify PBC immediately if I discover any claiming activity that is unknown or suspect.

If PBC finds that any false or misleading claims have been submitted by my provider on my behalf, PBC may take action to correct any inaccurate claiming activity. If it is found that I colluded in allowing the provider to submit false or misleading claims on my behalf PBC may recover such amounts from me, suspend my benefits or privileges, and/or exercise the right of set-off.

I have read and understand this Patient Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

For additional information regarding the Pacific Blue Cross privacy policy and/or the collection, use or disclosure of my personal information, I can visit https://www.pac.bluecross.ca/privacy.

Patient's signature (or parent/guardian)	Date (mm-dd-yyyy)
X	

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