Ontario College of Pharmacists
Putting patients first since 1871

Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Therapist or Counsellor Information - Part I

To be completed by the Therapist

I,_____(the "Therapist") am providing/propose to provide therapy or counselling to_____(the "Applicant"), who is requesting funding under the Patient Relations Program established by the Ontario College of Pharmacists (OCP). In so doing, I hereby acknowledge:

1. I do not have any family or personal relationship with the Applicant or any other potential conflict of interest.

2. I understand that the maximum amount of funding payable to any therapist or counsellor approved under this, or any other application to the College, is the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.

3. I understand that funding may only be used to pay for therapy or counselling for treatment related to allegations of sexual abuse by registrant of the Ontario College of Pharmacists and shall not be applied directly or indirectly for any other purpose.

4. I understand that the funding is to be used by the Applicant at their discretion over the next five years.

5. My hourly rate for this Applicant is $_____.

6. **I understand that there can be no duplicate payment for the same service.**

   To my knowledge the Ontario Health Insurance Plan (OHIP), private insurer or other source of funding, is not covering the costs associated with the therapy or counselling. If at any time, OHIP or a private insurer can pay for the therapy or counselling, I shall notify the Ontario College of Pharmacists. The amount funding provided by the College will be reduced by that amount. Please review and confirm these options with the patient.

7. I am a regulated health professional and a licensed/registered memberof:

   _____.

OR

I ceased to be a member of _____ in (dd/mm/yy) _____.

OR

I have never been a member of a regulated health profession. I have explained to the Applicant that I am not subject to discipline or required to follow professional standards and expectations as

set out by the Ontario College of Pharmacists or any other regulatory body.

8. I have not at any time or in any jurisdiction been found guilty of professional misconduct of any kind.

9. I have never been found liable, criminally or civilly, for an act of a sexual nature.

10. I understand that the College may verify the service dates with the Applicant.

11. Attached is proof of my professional credentials including any registration information with a regulatory body (if applicable).

12. I undertake to keep confidential all information obtained through and related to the College's Patient Relations Program and to refrain from using that information for any purpose other than to provide therapy to the Applicant.

13. All patient health information/care plans should be discussed directly with the Applicant and not with the College. Funding amounts and balances must also be discussed directly with the Applicant. In the administration of the funding program, the College does not allocate funding for specific services and therapists cannot request a change or propose an approach to the administration of funds directly with the College. A formal request for specific use of funds must be submitted by the Applicant for consideration. I understand that the administration of the Patient Relations Program is separate and distinct from the complaints/discipline process at the College.

14. I understand the College will not reimburse any fees associated with late or missed appointments.

15. Only payment for services provided to the Applicant will be issued by the College. Each invoice must be submitted to the College with a copy of Form D and payment will be made directly to the therapist/counsellor.

16. I will invoice the College directly for reimbursement of the therapy and counselling services I provide to the Applicant and that I will issue invoices (including date, duration of session, and rate) by email in confidence to patientrelations@ocpinfo.com.

17. I confirm that the information contained in this form is correct to the best of my knowledge.

Therapist/Counsellor training and experience: please attach curriculum vitae and identify any specific training/experience related to providing therapy/counselling to survivors of sexual abuse.

_____

Therapist's Signature

_____

Print Name

_____

Date

Contact Information:

Name of Therapist: _____

Name of Clinic: _____

Address: _____

City:_____Province:_____Postal Code: _____

Telephone:_____ Email: _____

Please submit forms to:

patientrelations@ocpinfo.com

Patient Relations Program
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Questions?

Please direct all questions to patientrelations@ocpinfo.com to ensure a timely response to your inquiries regarding the Patient Relations Program. This account is secure, confidential, and monitored by dedicated staff members at the College.

More information is on our website