College of Opticians of Ontario

(416) 368-3616
(800) 990-9793 (Toll-Free)
(416) 368-2713

FORM B: Therapist/Counsellor Information

Therapist/Counsellor Name: _____

Telephone: _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

By signing this document, I acknowledge and agree to the following:

1. I am providing/proposing to provide therapy or counselling to _____ (the "Applicant"), who is applying for funding under the program established by the College of Opticians of Ontario (the "College") for persons who have made an allegation of sexual abuse against a member of the College.

2. I do not have a family relationship to the Applicant or any other potential conflict of interest.

3. I understand that funding may only be used to pay for therapy or counselling as determined by the Patient Relations Committee of the College.

4. 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 would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.

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

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

   ☐ To my knowledge, neither OHIP nor any other public/private insurer is required to pay for the therapy or counselling I provide/propose to provide to the Applicant. I will notify the College if any other source of funding becomes available to the Applicant.

   OR

   ☐ To my knowledge, some or all of the cost of this therapy or counselling is paid by OHIP or another public/private insurer.

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7. ☐ I am a member of the following regulated health profession: College of _____, and my Registration No. is _____.

   OR

   ☐ I have never been, or am not currently, a member of a regulated health profession and I have explained to the Applicant that I would not be subject to professional discipline by the College of Opticians of Ontario or any other regulatory body.

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

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

10. I understand that I must sign and submit a copy of Form D (Therapy Invoice Submission) with each invoice for therapy/counselling that I submit to the College.

11. I understand that there will be no payment by the College for late or missed appointments.

12. I understand that I must keep confidential all information obtained through the application for funding process, including, if funding is granted, the fact that funding has been granted and the reasons given by the Patient Relations Committee for granting the funding, and to refrain from using that information for any other purpose.

13. By signing this form, I agree that the information I am providing is made in good faith and for no improper purpose

_____ _____

Signature of Therapist/Counsellor Date