Therapist/Applicant Information Form – Form B

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COLLEGE OF CHIROPODISTS OF ONTARIO
Regulating Chiropodists and Podiatrists in Ontario

Therapist/applicant information form

The Patient Relations Committee follows the rules and regulations made into law by the Government of Ontario, which direct the College in administering this funding program. This form is to be completed once the applicant has chosen a therapist and is required before funding can be provided.

The therapist must complete Part I and the applicant must complete Part II.

PART I – To be completed by the therapist

I,_____, (the therapist) am providing or propose to provide therapy and

counselling to:_____(the applicant), who is applying for funding under the program established by the College of Chiropodists of Ontario (the College).

I declare that:

1. I am not related to the applicant through family or by marriage. I do not know of any conflict of interest or any potential conflict of interest.

2. I understand funding provided by the College may only be used to pay for therapy and counselling and is determined by the College's Patient Relations Committee.

3. I understand that the maximum amount of funding payable to any therapist 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. Unless retroactive funding is requested (Form C), payment for services provided will begin on the day that the Patient Relations Committee determines that the applicant is eligible for funding.

4. My hourly rate for this patient is $_____.

5. To my knowledge, neither OHIP nor any private insurer is required to pay for the therapy and counselling I propose to provide/provide to the applicant.

6. If submitting a request for past therapy costs (Form C), I agree to reimburse the applicant directly in return for funds that are received from the College.

7. ☐ I became a member of _____ in _____.
   Regulatory body year

   ☐ I ceased to be a member of _____ in _____.
   Regulatory body year

OR

☐ I have never been a member of a regulated health profession. I have explained to the applicant that I would not be subject to professional oversight by any regulatory body.

8. To my knowledge, no other sources of funding for therapy and counselling are available to the applicant, except the following:

   _____
   Name of provider and amount available
   If at any time other sources of funding become available to the applicant, I shall notify the college and, where appropriate, cease submitting claims to the College. I understand that there can be no duplicate payment for the same service.

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

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

11. I have attached a copy of my curriculum vitae and a summary of my training and experience, particularly with respect to my ability to provide therapy and counselling to survivors of sexual abuse.

12. I will keep confidential all information obtained through the application for funding process, including that funding has been granted and the reasons given by the Patient Relations Committee. I will refrain from using that information for any collateral or other purpose.

13. I understand there will be no payment by the college for fees related to late or missed appointments.

_____ _____
Signature of Therapist Date

PART II – To be completed by the applicant

I have read the information provided by the therapist/counsellor. It is all correct.

_____ _____
Signature of Applicant Date