

Consent to Engage with Talking Based Therapy:

This form provides information about the Poukōrero Rongoā – Talking Based Therapy (TBT) Service and seeks your consent to participate.

By signing you acknowledge and understand the following information about the Poukōrero Rongoā – TBT Service:

Poukōrero Rongoā - TBT therapy:

- Sessions are 50–60 minutes long and may be held in-person or via telehealth (phone or online).
- You may access up to **4 sessions** of talking therapy in a 12-month period.
- If your assigned therapist is not a good fit, you may contact the TBT Coordinator by phone/text 021391162 to discuss alternatives.
- Following the first session further appointments will be scheduled between you and your therapist.
- Clinical responsibility for your health remains with you and your GP team.
- Sessions are not recorded. If you wish to record a session, please discuss this with your therapist beforehand.

Cancellations and Changes to Appointments:

- If you are unwell, have been exposed to Covid-19, or your appointment time no longer suits you, please contact our TBT Coordinator or your therapist as soon as possible to reschedule.
- Cancellations made less than 24 hours before the appointment may count as one of your allocated sessions.
- Two cancellations or two missed appointments may result in you being discharged back to your GP.

Children/Young People:

- Clients under 16 years old must have guardian consent to attend.
- It is the consenting guardian's responsibility to inform other relevant parties that the child or young person is attending this service.

Storage of Information:

- Your contact details and session notes are stored in a secure internal patient management system, in accordance with legal requirements.

Accessing Your Information:

- You have the right to access and request corrections to your information; to do this contact the TBT Coordinator by email at mentalhealth@healthhb.co.nz.

Limitations to Confidentiality:

We are committed to maintaining your privacy. However, we may need to share your information in the following situations:

- Serious safety concerns for you or others (e.g., personal safety, family violence, child protection).
- Legal obligations requiring disclosure.
- Responding to a complaint about the service.

Information Sharing:

- As this service is an extension of your GP practice, a summary will be sent to them on completion.
- Therapists work as part of a team and consult when required, client identity is protected when possible.
- When required we can provide confirmation that you attended TBT sessions but are unable to provide support letters regarding your character or personal testimonials.
- If a third party contacts us regarding your information, we will first confirm that we have your consent to provide information.
- Health New Zealand – Te Whatu Ora - Te Matau a Māui are the funders of this service and require us to share details about the TBT Service to help them plan future health services. The information provided includes date of birth, gender, ethnicity, suburb, and relevant details about the use of the service. At times your NHI number may be requested. This information will only be provided if you agree.

Please circle below whether you consent to your NHI number being included with the other information we must provide.

YES

NO

We adhere to the following legislation to protect your rights and privacy:

- Privacy Act 2020
- Health Information Privacy Code 2020
- The Code of Health and Disability Services Consumers' Rights – <http://www.hdc.org.nz>

Feedback and Complaints:

- We welcome your feedback to help improve our service.
- You may be asked to complete an anonymous survey after your final session. Alternatively, you can email feedback to mentalhealth@healthhb.co.nz
- All complaints will follow our complaints process. You can make a complaint by following this link [Connect with us - Health Hawke's Bay \(healthhb.co.nz\)](#) or contacting the TBT Coordinator on 021391162 or email mentalhealth@healthhb.co.nz outlining the details of your concerns.

I consent to take part in talking therapy with _____ (Talking Based Therapist)
I have the right to withdraw my consent at any time.

Name: _____ NHI: _____ or DOB: ____/____/____

Signature: _____ Date: ____/____/____