First Nations and Inuit Health Branch
Non-Insured Health Benefits (NIHB) Program
Indian Residential Schools Resolution Health Support Program (IRS RHSP)

MENTAL HEALTH COUNSELLING APPOINTMENT CONFIRMATION

► **Please complete one form per client for sessions attended.**

Privacy Act Statement

The personal information you provide to ISC is governed in accordance with the *Privacy Act*. We only collect the information needed to administer the NIHB Program and IRS RHSP. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the *Privacy Act.* For more information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to and correction of your personal information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at www.tbs-sct.gc.ca/hgw-cgf/oversight-surveillance/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

Program Billed

☐ Indian Residential Schools - Resolution Health Support Program (IRS RHSP)

☐ Non-Insured Health Benefits (NIHB) - Mental Health Counselling (MHC)

NOTE ► The Client is not to be asked to sign the form in advance.

Client Information

Given Name	Family Name
Parent or Legal Guardian Name (If applicable)	IRS RHSP Eligibility Number/IRSAS Verification Number (if available)

Provider Information

Given Name				Family Name		
Vendor Number (7-digit)		Invoice Number		Telephone Number	Email Address	
Date of Service (YYYY-MM-DD)	Start Time/ End Time	Duration/ Number of Hours Used	Modality of Session (Check One)	Client or Guardian Signature I acknowledge that I have received the counselling services indicated below (**Only sign after the session is complete**)		
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Signature **X**	Print Name	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Signature **X**	Print Name	Date (YYYYMMDD)
	From: To:		◯ Face-to-Face ◯ Telephone/ Video-conferencing	Signature **X**	Print Name	Date (YYYYMMDD)

IMPORTANT ► ISC reserves the right to request additional information as necessary.

Provider's Signature	Date (YYYYMMDD)
X	