RCDSO | Royal College of Dental Surgeons of Ontario

REQUEST FOR PAST THERAPY/COUNSELLING COSTS

This form is completed by the applicant. The College may reimburse applicants for past therapy/counselling costs they personally incurred in the following circumstances:

- *the therapy/counselling was provided any time after the alleged sexual abuse took place;*
- *the past therapy/counselling costs have not been paid by any provider;*
- *the applicant or therapist/counsellor provides invoices or receipts with therapy dates and costs; and*
- *the therapist/counsellor agrees to reimburse the applicant, in return for funds paid directly to the therapist/counsellor.*

Applicant information:

FIRST NAME: LAST NAME:

ADDRESS:

PHONE: EMAIL:

I prefer to be contacted by: ☐ PHONE ☐ EMAIL ☐ MAIL

Other sources of funding (e.g., private health insurance):

_____ (name of provider) _____ (amount)

Therapist/Counsellor Information:

NAME OF THERAPIST/COUNSELLOR:

PRACTICE NAME (if applicable):

PRACTICE ADDRESS:

BILLING ADDRESS:
(if different from practice address):

PHONE: EMAIL:

Therapy/Counselling Information:

Dates of therapy/counselling sessions (YYYY – MM – DD)	Amount of session	Amount requested (if different from amount of session)

TOTAL AMOUNT REQUESTED: $ _____

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

1. I am claiming reimbursement for therapy/counselling sessions that occurred after the alleged sexual abuse. All costs associated with these sessions were for my therapy/counselling.
2. I have used all other sources of funding available to me before claiming reimbursement for these past therapy/counselling costs.
3. I paid out-of-pocket for these past therapy/counselling costs and have not already been reimbursed for them. I understand that there can be no duplicate payment for the same service.
4. I am, or my therapist/counsellor is, providing receipts or invoices for the past therapy/counselling costs I am seeking reimbursement for.
5. I understand that my therapist/counsellor has to agree to reimburse me, in return for funds that the College will pay directly to the therapist/counsellor.
6. My therapist/counsellor meets the requirements set out in legislation, including:
    A. My therapist/counsellor is not in a family relationship with me or does not have any other potential conflict of interest. I understand and agree that the term "family relationship" includes any family relationship established through marriage.
    B. The therapist/counsellor has not, at any time, or in any jurisdiction, been found guilty of professional misconduct of a sexual nature, or been found liable, criminally or civilly, for an act of a sexual nature.
7. I undertake to keep confidential all information obtained through the application for funding process and refrain from using this information for any other purpose.
8. I confirm that the information contained in this form is correct to the best of my knowledge and will update the College if any of the information in this form changes.

Signature of applicant

Date (YYYY – MM – DD)

How to submit the form(s)

Email us
patientrelations@rcdso.org

OR

Print the form and mail it to us at
RCDSO Attn. PRC
6 Crescent Road, Toronto, ON M4W 1T1

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