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|  | **Oregon Health & Science University**  **Hospitals and Clinics**  CO1400  \*CO\_\_\*  **CASEY EYE INSTITUTE**  **SUPPORT GROUP PROGRAM**  **TERMS OF PARTICIPATION**  Page 1 of 2 | **ACCOUNT NO.**  **MED. REC. NO.**  **NAME**  **BIRTHDATE**  *Patient Identification* |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant’s name) hereby consent to participating in the Support Group Program (Program). This Program enables participants, who are experiencing similar diagnoses and challenges to connect with one another, in a group session run by a Casey Eye Institute (CEI) social worker. The Program’s goals are to help participants process the impact that these diagnoses have on daily living, school, work, family life, etc.; assist participants and families to learn adaptive strategies and skills; and learn about available community resources.

To ensure you understand how the program will operate, we require you to read and sign these terms, thereby agreeing to the following conditions. Please initial each line.

\_\_\_\_I understand that the purpose of the Program is for Program participants to share practical information, mutual aid, resources and emotional support, and not for the purpose of obtaining or providing medical advice, care or treatment.

\_\_\_\_ I understand that OHSU’s virtual meeting tool will display and disclose my personal demographic information (including name and image, phone number and/or email address). By joining the virtual meeting, I am agreeing and directing OHSU to display and disclose this information to the other support group participants.

\_\_\_\_I understand that the information I provide to, and/or receive from, other Program participants, is NOT medical advice, care or treatment or a medical recommendation. Should I have a medical question, I will consult with my provider.

\_\_\_\_I recognize that I must use my own discretion during support group conversations relative to what I disclose to the group or share with the group. I understand that any information I share will be kept confidential by the CEI social worker and that the CEI social worker will discuss confidentiality expectations with all group members. However, I also understand that the other group members may not choose to keep the information discussed in group sessions confidential and that they may disclose the information I share in the group with others including individuals outside the group setting.

\_\_\_\_I understand that there is no out of pocket cost to participate in the Program, and that my insurance will not be billed for any part of my participation in the Program.

\_\_\_\_I understand that my role as a participant in the Program is to share my own personal experience, and that I may choose to share as much or as little of my own personal experience as I desire.

\_\_\_\_I agree to maintain appropriate boundaries at all times when participating in group sessions and should any issue arise, I will bring it to the attention of the social worker and/or my provider. Appropriate boundaries include but are not limited to the following:

1. At all times showing respect for others and their opinions, perspectives and viewpoints even if different from mine.
2. At all times utilizing respectful communications and following group etiquette
3. At all times allowing others to share in group and waiting my turn to share in group
4. At all times maintaining confidentiality relative to what is shared in group and not disclosing same to third parties or other individuals outside of group sessions.

\_\_\_\_ I agree not to attempt to provide medical advice or medical information to other group members including but not limited to advice related to managing their or their family members’ medical diagnoses.

\_\_\_I agree that if I choose to no longer participate in the Program or if I have any questions or concerns related to the Program, I will contact the Casey Eye Institute social worker, Tara Albury, at 503-494-1618.

\_\_\_I agree that if I have an urgent medical condition or a medical emergency, I will contact my physician, call 911 and/or go to the nearest emergency department.

\_\_\_ I understand that OHSU may terminate my participation in the Program if I fail to adhere to the terms outlined herein, as determined by OHSU in its sole discretion.

I have read, understand and accept all of the above terms.

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