

**Mickey Stein, Ph.D.**  
**Registered Psychologist (#2413)**

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## **Office Policies and Informed Consent for Psychological Services**

Welcome to my practice! The following is some important information about psychotherapy and about the office policies.

**Confidentiality:** All communication during the course of therapy is strictly confidential and will not be disclosed to anyone without your written permission except in situations where disclosure is necessary to prevent harm or is required by law. Disclosure may be required in the following circumstances with or without your permission:

- If there is reason to believe that anyone under the age of 19 years, or a vulnerable adult, needs protection from abuse or neglect of any kind.
- If there is reason to believe that you are in immediate and serious danger of harming yourself or someone else.
- As demanded by a court order.
- If you are driving and you are considered unsafe to drive a motor vehicle.
- If there is reason to believe another registered healthcare professional presents a danger to the public in the practice of his or her profession.

**Risks and Benefits:** Psychotherapy is a collaborative effort, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions such as fear, anger, depression, anxiety, frustration, and loneliness. However, psychotherapy has also been shown to have many benefits for those who follow through with the process including more fulfilling relationships, solutions to specific problems, reduction in feelings of distress, improved coping skills, and greater life satisfaction and personal growth. Open and honest communication is essential to a positive outcome in psychotherapy, and you are encouraged to voice any concerns or questions about our work together.

**Payment for Service:** The fee is \$225.00 for a 50-minute individual psychotherapy session. A sliding scale fee is available under certain circumstances. Payment is expected at the time of service unless we have explicitly made another agreement. Please inform me if any problem arises during the course of your treatment regarding your ability to make timely payments. Should collection efforts be required to collect outstanding balances, please be aware that you are responsible for any and all fees incurred in this process. A collection service will never be used to collect outstanding balances without first trying to arrange an alternate payment plan or discuss other options with you. Should I have to resort to a collection agency, you will be notified prior to doing so.

**Payment Methods:** Fees must be paid in full at the beginning of each appointment unless alternate third party payment arrangements have been made in advance. I accept

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payment by cash, e-transfer, checks, and credit card. Please note, that there will be additional \$5.00 charge when using credit cards.

**Insurance:** Professional services are rendered and charged to the client, not the insurance company. Therefore, any charges are the responsibility of the client. You are responsible for verifying your mental health benefits as well as filing all insurance claims.

**Cancellation Policy:** Please provide 48 hours notice if you need to cancel your appointment. If you cancel within 48 hours, the following pay structure will be used (unless it is an unavoidable emergency):

- 1 missed session: \$50.00
- 2 missed sessions: \$100.00
- 3 missed sessions: \$150.00
- 4 missed sessions: \$200.00
- 5+ missed sessions: \$225.00

**Telephone Calls:** My voicemail is on at all times. Please be sure to leave me your name and number, even if I already have it, and some good times to reach you. Although I attempt to return calls in a timely manner, please know that a response to your call may take up to 24 hours.

**Skype or Telephone Calls:** The use of internet voice and video conversation is a secure form of communication that is encrypted to protect your privacy. Cell phones offer the least amount of protection, landlines being fairly better. Of course, with any method of communication, there is the possibility that could lead to a breach of privacy and therefore confidentiality.

**E-mail:** Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all e-mails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

**Emergency or Crisis:** If you are experiencing an emergency or crisis, please call 911, the BC Phone 1-800-SUICIDE (1-800-784-2433), the Crisis Intervention & Suicide Prevention Centre of BC (24/7 Distress Phone Service: 604-872-3311 or 1-866-661-331), or go to the nearest hospital emergency room.

**Physician Contact:** Physical and psychological symptoms often interact. You are encouraged to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems.

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**Questions:** I welcome any and all questions about psychotherapy, my office policies, and your privacy rights. Please feel free to bring up any issues of concern at any point.

Dr. Mickey Stein is a registrant of the College of Psychologists of British Columbia and as such is governed by the College's Bylaws and Code of Conduct.

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Client Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

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**Personal Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone (Voicemail Okay (Y/N))

\_\_\_\_\_  
Cell Phone (Voicemail Okay (Y/N))

\_\_\_\_\_  
E-mail(s)

\_\_\_\_\_  
Current Medication(s)

\_\_\_\_\_  
Medical Conditions

\_\_\_\_\_  
Psychological Issues

\_\_\_\_\_  
Previous Psychological/Psychiatric/Counseling Services

\_\_\_\_\_  
Family Physician

**Emergency Contact Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
E-mail(s)