

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

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Informed Consent for Telepsychological Services

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

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Below, please include the names and telephone numbers of your local emergency contacts (including local physician; crisis hotline; trusted family, friend, or confidant).

| | |
|--------------------------------|---------------------|
| Physician or Psychiatrist Name | Telephone number(s) |
|--------------------------------|---------------------|

| | |
|--|---------------------|
| Crisis Hotline and local Crisis Center Names | Telephone number(s) |
|--|---------------------|

| | |
|-----------------------------------|---------------------|
| Family Member Name & Relationship | Telephone number(s) |
|-----------------------------------|---------------------|

| | |
|----------------------------|---------------------|
| Friend Name & Relationship | Telephone number(s) |
|----------------------------|---------------------|

Client Name:

Signature of Patient/Patient's Legal Representative:

Date: