



119 Bayview Street
P.O. Box 998
Marystown, NL A0E 2M0

Website: <http://guidinglightpsychology.ca>

Email: eric@guidinglightpsychology.ca

Phone: 709-277-5188

Fax: 709-279-4202

Informed Consent for Telepsychology Sessions

1. I understand that “telepsychology” includes secure videoconferencing, emails, telephone conversations, and education using interactive audio, video, or data communications.
2. Unless I explicitly provide agreement otherwise, telepsychology exchanges are strictly confidential. Any information I choose to share with my psychologist will be held in the strictest confidence. My private information will not be released unless I am required to do so by law. In Newfoundland and Labrador, psychologists are required to notify authorities if they become convinced a client is about to physically harm someone, harm themselves, or if they are abusing or about to abuse children, the elderly, or the disabled.
3. I understand that telepsychology services are furnished in Newfoundland and Labrador, and the services provided are governed by the *ACPRO Telepsychology Model Standards*, and *Association of State and Provincial Psychology Boards (ASPPB) Telepsychology guidelines*.
4. I understand that I have the right to withdraw or withhold consent from telepsychology services at any time. I also have the right to terminate treatment at any time.
5. While telepsychology will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with telepsychology services including, but not limited to, the possibility that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.
6. I will work with my psychologist to identify an alternative communication method (most often phone) if the videoconferencing tool fails.
7. I understand that I may benefit from telepsychology but that results cannot be guaranteed or assured.
8. 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 when able.
9. I understand and accept that telepsychology does not provide emergency services. If I am experiencing an emergency, I understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I may also call the Mental Health Crisis Line 737-4668 or 1 888 737-4668

10. I will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for my telepsychology sessions, (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telepsychology sessions.
11. I agree not to record telepsychology sessions.
12. I agree to be dressed as if I were attending an in-person face to face session.
13. I have the right to access my medical information and copies of my medical records in accordance with the *Personal Health Information Act (PHIA)* and *Access to Information and Protection of Privacy Act (ATIPPA)* as well as other applicable laws.
14. If we are concerned about you or we lose contact with you, or if you fail to show for a scheduled session, we will contact you by phone to check on your well-being. In addition, if you are showing signs of being in real trouble, we require that we have permission to contact someone to ensure your safety. We require three levels of contacts: Close personal contact such as a parent or spouse.

Name: _____ Relationship: _____

Phone: _____

Professional contact such as a personal physician or other health care professional

Name: _____ Profession: _____

Phone: _____

Office or Agency that does crisis well-being checks in your community
(typically a 24-hour crisis service or the police department).

Local Crisis Agency and Phone Number: _____

Client Signature/Print Name

D.O.B. (DD/MM/YYYY)

Signature Date (DD/MM/YYYY)
