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Stacy E. LaMorgese, Psy.D.
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East Valley Counseling Associates

Consent for treatment of Minors (Under 18)

Child's Name _____ Date of Birth _____

I/We _____ am/are the legal custodial

parents/guardians of _____ and give my/our permission to Dr. Stacy E. LaMorgese, Psy.D. to provide psychological services to my/our child.

If the child's biological parents are not together, please complete:

What is the custody arrangement of this child? (Joint or sole Decision Making?) _____

Who is primary Decision Maker if not Joint? _____

If applicable, please describe the child's current visitation schedule: _____

_____

_____

1. I/we have been informed of my/our rights and responsibilities as the parent(s) of a patient of Dr. Stacy LaMorgese, Psy.D.
2. I/we have been informed about the limits of confidentiality of my/our child's records.
3. I/we have been informed of the cost of services from Dr. LaMorgese. I understand that I/we are responsible to pay the agreed rate for service and that it is payable each time I/we bring our child for treatment.
4. I/we have been informed of Dr. LaMorgese's qualifications. I/we areaware that Dr. LaMorgese is not a fully licensed independent Psychologist but an Associate Psychologist working under the direct supervision of Dr. Daniel J. Christiano and/or Dr. Mary Ann Thirakul.
5. I/we understand that I/we may address any concerns or grievances with the therapist/doctor at any time. I understand that I/we may also contact her direct supervisor, Dr. Daniel J. Christiano and/or Dr. Mary Ann Thirakul.
6. I/we are freely choosing to enter my/our child into treatment, and I/we understand that I/we may discontinue treatment at any time. However, I/we agree to let Dr. LaMorgese know before stopping treatment.

7. I/we agree that if at any time I/we feel that our child may be a threat to self or others, I/we will call Dr. LaMorgese, another doctor at EVCA, or Banner Helpline (602) 254-4357 before calling 9-1-1.

8. I/we give my/our authorization and consent for my/our child to receive outpatient diagnostic and treatment services from Dr. LaMorgese. I/we understand that the therapist/doctor believes that this treatment will help the child and there is no guarantee as to the result. I/we also understand that, on occasion, there can be negative consequences to treatment and I/we agree to inform Dr. LaMorgese if there are unexpected changes in the child's condition.

Signatures:

_____	_____	_____
Parent Signature	Parent Printed Name	Date
_____	_____	_____
Parent Signature	Parent Printed Name	Date