Daniel J. Christiano, Ph.D.
Stacy E. LaMorgese, Psy.D.
4115 East Valley Auto Drive, Suite 208
Mesa, Arizona 85206
480-507-7880
Fax 480-507-8013

East Valley Counseling Associates

INFORMED CONSENT FOR TREATMENT

I _____DOB_____SSN_____

1. I have been informed of my rights and responsibilities as a patient of Dr. Stacy LaMorgese, Psy.D.

2. I have been informed about the limits of confidentiality of my records.

3. I have been informed of the cost of services from Dr. LaMorgese. I understand that I am responsible to pay the agreed rate for service and that it is payable each time I come for treatment.

4. I have been informed of Dr. LaMorgese's qualifications. I am aware 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 understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact her direct supervisor, Dr. Daniel J. Christiano and/or Dr. Mary Ann Thirakul.

6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time. However, I agree to let Dr. LaMorgese know before stopping treatment.

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

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

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Signature of patient or legal consenter Date

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Signature of staff providing the information