Stacy E. LaMorgese, Psy.D.
Clinical & Forensic Psychologist
4115 East Valley Auto Drive, Suite 208
Mesa, Arizona 85206
480-507-7880 Fax 480-507-8013

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. and/or a student she supervises 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 are aware that Dr. LaMorgese is a fully licensed independent Psychologist and supervises students who may provide assessment and treatment as well.
5. I/we understand that I/we may address any concerns or grievances with Dr. LaMorgese at any time.
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