Jerry G. Soucy, Ph.D.
Licensed Psychologist #Psy 10209
16152 Beach Blvd. Ste. 281
Huntington Beach, Calif. 92647
714-842-7060

INFORMED CONSENT FOR TREATMENT

I hereby request that _____
(patient name)

date of birth_____who resides at _____
(Street address)

_____
(City/State) (Zip Code) (Telephone number)

be accepted for outpatient and/or telepsychological mental health treatment by Dr. Jerry G. Soucy.

1. I give my authorization and consent to receive diagnostic and mental health treatment from Jerry G. Soucy, Ph.D., Licensed Psychologist.
2. I have been informed of my rights and responsibilities as a mental health patient.
3. I have been give information regarding the limits of confidentiality of my records.
4. I have been given information regarding the costs of services from Dr. Soucy. I understand that I am responsible to pay for these services in whole or in part (if using health insurance) either after each treatment visit or immediately after my monthly billing statement.
5. I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.
6. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives as may be appropriate.

_____ _____
(Date) (patient/parent signature)

_____
(Date) (Witness)