Taji Huang, Ph.D.
Licensed Psychologist

License # PSY 22717
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Informed Consent

I_____ consent to the evaluation/treatment process with Dr. Marie Diaz and I understand my rights and responsibilities as are described below:

I understand that therapy is a joint effort, the results of which cannot be guaranteed. Progress in treatment will depend upon many factors including but not limited to: motivation, effort, and consistency in attendance and other life circumstances.

I understand that all information disclosed within my sessions is confidential and may not be revealed to anyone without my/our written permission, **except in the following situations:**

- **When disclosure is required by law (upon reasonable suspicion of child, elder or adult dependent abuse).**

- **When I waive my right to confidentiality in a court of law.**

- **When I am believed to be a serious dangerous to myself (imminently suicidal) or, when there is imminent, identifiable, life-threatening danger to another person or property.**

It is my duty to inform you that under the USA Patriot Act, which authorizes certain FBI agents to request a subpoena from a special court for your records. The FBI could request your records and access to any requested records **must be granted without your prior or any approval or notification.** Signature: _____ Date: _____

Psychological Associate Services - If you are working with my Psychological Assistant Dr. Marie Diaz, Psy.D. (PSB 94026010), it is my responsibility to inform you that she is unlicensed and is allowed to provide limited psychological services only while under the direction and supervision of a licensed supervisor. By signing this form you are agreeing to release your confidential information so I can access this information related to my supervision duties. Signature: _____ Date: _____

I agree to the fee of $175.00 per hour and I understand that payment of the fee in full is required at the beginning of each session**.**

I also understand that Dr. Huang's rate is $87.50 per 30 minutes or $262.50 for 90 minutes.

I also understand that cancellations without a full 24 hours notice will be billed at the full session rate ($175.00). In addition, I understand that there is a $25.00 return check fee for each returned check. (Signature:_____Date:_____)

I further understand that my signature on this form serves as consent for treatment and that I may withdraw from treatment at any time.

Print Name_____

Signature_____ **Date**_____