Taji Huang, Ph.D.
Licensed Psychologist

License # PSY 22717
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Informed Consent

I_____ consent to the evaluation/treatment process with Dr. Taji Huang 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: _____

The session fee is $300/hr or $450 for 1.5 hours. You will be expected to pay your session fee at the onset of our session

Payment is due in the form of Venmo, Zelle, or credit card (a small service charge will be applied for credit card payments only) for the session.

I also understand that cancellations without a full 24 hours notice will be billed at the full session rate ($300).____

(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_____