

**Informed Consent for Assessment Consultation**

**1439 E. Chapman Ave.  
Orange, CA 92866**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

The fee for Initial Assessment Consultation session is \$\_\_\_\_\_ to be rendered at the time of service. Twenty-four hour cancellation is required to avoid being charged for the appointment. The purpose of these sessions is to determine your needs and to help you decide what form(s) of psychological consultation may be desirable. These sessions are for assessment only. Any other psychological services are offered under a separate fee schedule and service agreement.

**Reason for seeking Consultation:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you have health insurance:**

Name of company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Note:** I will gladly provide you with a bill for these initial sessions for Managed Care coverage. But longer treatment and couple counseling is not a Managed Care benefit.

(Continuation on reverse side)

(Continuation from side one)

I agree to submit any disagreement regarding services or complaints regarding breaches in law or ethics to binding arbitration under the auspices of the American Arbitration Association located in Irvine, CA. I further agree to pay any and all legal costs arising from complaints that are not fully validated by the arbitrator.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Release of Confidential Information**

Are you currently in therapy? \_\_\_\_ Yes \_\_\_\_ No

If so, who is your current therapist?

1.  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Who are your past therapists? Or who is your current psychiatrist?**

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Note:** The ethics of the American Psychological Association require that therapists obtain records from current and previous psychotherapists in order to work with you. Should we decide to continue services beyond a few assessment sessions an Informed Consent for Treatment will be provided and agreed on.

I hereby give permission to the above named therapist (s) to release their confidential records to:

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