

Better Days Ahead, LLC
Gianny Diaz, LCSW, CSAT, EMDR certified
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Name _____

Date of Birth _____

Authorization For Treatment/Informed Consent

I, _____, consent to be assessed and receive psychotherapy services from Gianni Diaz, I am aware that treatment involved is not an exact science and that no guarantee has been made to me as to the result of this treatment. I understand that psychotherapy is a cooperative effort and I understand that a cooperative effort is needed to resolve difficulties. My choice has been voluntary and I may withdraw consent for treatment at any time. In addition, all information is held confidential and only broken upon either imminent danger to self, child, elderly, court order and/or if authorized by client to release information.

Patient Signature

Date

Appointment Attendance & Discharge Policy:

Regular attendance is required to reach your therapeutic goal(s). If you fail to attend, late cancel, or do not schedule a session within two consecutive weeks (14 calendar days), it is considered an uncommunicated break in care. In such cases, your therapist will consider this as a unilateral termination of therapy. You will be discharge from practice on that day, receive an email of your discharge date, and your designated time slot will be given to another client. You may initiate the process to reopen your case or resume scheduling at any time. If you understand and agree please sign and date below.

Patient Signature

Date