# Better Days Ahead, LLC

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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization For Treatment/Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to be assessed and receive psychotherapy services from Gianny 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 and/or if authorized by client to release information.

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Patient Signature Date