Better Days Ahead, LLC
Gianny Diaz, LCSW, CSAT, EMDR trained
Phone: 786-383-2370
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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.

_____ _____

Patient Signature Date