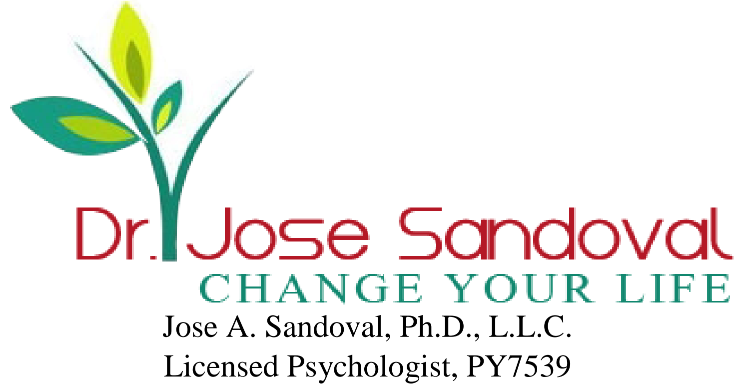

Jose A. Sandoval, Ph.D., L.L.C.
Licensed Psychologist, PY7539

INFORMED CONSENT FOR CONSULTATION

Name____

Address: ____________________________________Email:_________________________

Today's Date: _____________ Date of Birth: _______________ Phone: _________________

Reason for seeking consultation: ____

____

I understand that I may withdraw my consent for specific services or treatment at any time to the extent permitted by law. I am aware that I must submit my withdrawal in writing. The fee for the consultation is $55.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ The purpose of this consultation is to determine your needs and to help you decide what services will be most appropriate for you. At this point, you are not a client of Dr. Jose Sandoval.

_____ I understand that if I choose to become a client of Dr. Jose Sandoval, I must review and sign an Informed Consent for Treatment form to begin the process.

_____ I understand that all services provided are confidential with the following exceptions: if there is a threat of harm to self or another person, a report of child or elderly abuse/neglect, or a court order.

____ ____________________

Signature Date