Michael DiBiasie, Ph.D.

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Informed Consent to Receive Psychological Services

Welcome to Michael DiBiasie, Ph.D., Center for Relationships, mental health services. Our goal is to provide you with quality mental health care. Your informed participation and your understanding of payment arrangements are essential to our effort to help you, as well as to your effort to benefit from our time together. The following statements describe our agreement regarding the services that we will provide you.

I, _____, give my consent to receiving psychological services from Michael DiBiasie, Ph.D.. I understand treatment will involve:

- My explanation of the problem and the change I desire to make.
- A new perspective offered by my therapist on the problem(s) I have identified.
- Dialog regarding possible solutions.

I am voluntarily and freely making this decision to receive this treatment.

I understand that there are certain risks associated with receiving these services, including but not limited to, increased distress and increased anxiety or depression. I also understand that there are possible benefits with these services, including:

- Increase peace of mind.
- Desired changes in my behavior.

Reasonable alternatives or additions to this therapy have been explained to me including:

- The prescribed use of psychotropic medication as directed by a physician.

- Seeking counsel of another person, e.g., my pastor, friend.
- Choosing to do nothing or to simply wait for change to occur spontaneously.

I understand that I have the right to ask questions about my treatment at any time. At this time all my questions regarding receiving psychological services have been answered to my satisfaction. I am authorizing my therapists, Michael DiBiasie, Ph.D. to perform these services.

Initial page 1: _____

I understand that my participation is voluntary. I understand that regular attendance will enhance the opportunity for improved outcome and that I may withdraw from treatment at any time, in according with the policy for doing so.

I have read this form fully and completely. I have had the opportunity to discuss with my therapist all aspects of treatment, have had my questions answered, and understand the treatment that is planned. I understand there are no guarantees stated or implied and that I am accepting the risks inherent in the course of receiving psychological services. My signature below acknowledges my understanding and agreement to the information stated above. I grant Michael DiBiasie, Ph.D. permission to perform the professional procedures deemed appropriate for my treatment.

_____
_____

Client signature date