

# Taji Huang, Ph.D.

## Licensed Psychologist

License # PSY 22717

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## **Informed Consent**

I \_\_\_\_\_ consent to the evaluation/treatment process with Dr. Marie Diaz and I understand my rights and responsibilities as are described below:

I understand that therapy is a joint effort, the results of which cannot be guaranteed. Progress in treatment will depend upon many factors including but not limited to: motivation, effort, and consistency in attendance and other life circumstances.

I understand that all information disclosed within my sessions is confidential and may not be revealed to anyone without my/our written permission, **except in the following situations:**

- **When disclosure is required by law (upon reasonable suspicion of child, elder or adult dependent abuse).**
- **When I waive my right to confidentiality in a court of law.**
- **When I am believed to be a serious dangerous to myself (imminently suicidal) or, when there is imminent, identifiable, life-threatening danger to another person or property.**

It is my duty to inform you that under the USA Patriot Act, which authorizes certain FBI agents to request a subpoena from a special court for your records. The FBI could request your records and access to any requested records **must be granted without your prior or any approval or notification.** Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Psychological Associate Services** - If you are working with my Psychological Assistant Dr. Marie Diaz, Psy.D. ( PSB 94026010), it is my responsibility to inform you that she is unlicensed and is allowed to provide limited psychological services only while under the direction and supervision of a licensed supervisor. By signing this form you are agreeing to release your confidential information so I can access this information related to my supervision duties. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to the fee of \$175.00 per hour and I understand that payment of the fee in full is required at the beginning of each session.

I also understand that Dr. Huang's rate is \$87.50 per 30 minutes or \$262.50 for 90 minutes.

**I also understand that cancellations without a full 24 hours notice will be billed at the full session rate (\$175.00).** In addition, I understand that there is a \$25.00 return check fee for each returned check. (Signature: \_\_\_\_\_ Date: \_\_\_\_\_)

I further understand that my signature on this form serves as consent for treatment and that I may withdraw from treatment at any time.

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_