JOANNE BARRON, PSY.D.
CLINICAL PSYCHOLOGIST, LIC: PSY25733
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# *INFORMED CONSENT*

Name _____ Date of Birth _____

Home Address _____

_____

Phone: home _____ work _____ cell _____

Person to notify in case of an emergency: (name) _____

Phone number _____ Relationship to person _____

Email Address----------

I understand that Joanne Barron, Psy.D. has an ethical and legal obligation to protect my confidentiality. However, confidentiality may be suspended and the proper authorities notified under the following circumstances:

- I present a danger to myself, another person, or property
- I become gravely disabled
- I disclose information regarding the neglect, physical or emotional abuse of a minor, dependent adult, or an elderly adult

On occasion, Joanne Barron, Psy.D. may consult with other professionals regarding my treatment. No identifying information will be revealed during these consultations, and confidentiality will be fully maintained.

***I understand that sessions are 50 minutes in length. If I need to cancel a session, I must do so at least 24 hours advance, or I will be financially responsible for the missed session. Cancelations must be made by phone only. I may pay by either check, credit card or cash; checks are made payable to Joanne Barron, Psy.D.***

I have read and agree to the policies as outlined above.

Name (please print): _____

Signature: _____ Date: _____