Dr. Jorge J. Asturias, PsyD, Inc.
A Professional Psychology Corporation

Informed Consent to Treatment

I_____(undersigned client or designated adult*) give my consent to **Dr. Jorge J. Asturias** ("Treatment Provider") to perform health care services determined to be necessary or advisable for the benefit of my and/or my minor son/daughter's healthcare.

Patient Name_____Date of Birth_____

Parent's Name of Minor_____

Dr. Jorge J. Asturias is a Licensed Clinical Psychologist in private practice who provides the following mental health services: individual psychotherapy (adult, adolescent, and child), couples and marital psychotherapy, group psychotherapy, psychological assessments, personal, professional and/or organizational consultations, mental health education, trainings, tele-psychology, and others. He specializes in treating a number of psychological disorders, including, but not limited to, depression, anxiety, substance abuse, trauma, grief, personality disorders, and others.

The undersigned understands that the client has the following rights:

1. Be informed of and participate in the selection of evaluation, treatment, rehabilitative, referrals, and case management services.
2. All of the services received are voluntary and the client has the right to request a change in service provider and service coordination, as well as to withdraw this consent at any time.
3. The Client agrees that should his doctor be subpoenaed to testify as a witness in a trial, either to provide fact or expert testimony, the client shall be responsible to pay the doctor a fee of **$3,000 a day**. The fee shall be paid at the time the subpoenas, in advanced of testimony.
4. **Private Insurance Patients:** I hereby give authorization to release direct payment from my insurance company to Dr. Asturias. I understand that as a courtesy Dr. Asturias, and/or the office of Dr. Asturias designated to bill insurance companies, will bill my insurance company for services rendered. **I ACKNOWLEDGE THAT IT IS STILL MY RESPONSIBILITY TO ENSURE THAT FULL PAYMENT IS RECEIVED. I FURTHER UNDERSTAND THAT I MAY BE LIABLE FOR PAYMENT OF SERVICES DENIED, PARTIALLY OR FULLY, FROM MY INSURANCE COMPANY_____**(initials).

5. I understand that Dr. Asturias will act in good faith and to the best of his knowledge and capacity in providing his expertise on my behalf. However, he does not make any guarantees and is not responsible for the outcome of the treatment.

_____ _____

Signature of Client or Authorized Parent/Guardian/Adult Date

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