DR. GINA MADRIGRANO
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Ontario Licensed Psychologist (CPO#3705)
Quebec Licensed Psychologist (OPQ# 08193-98)

INFORMED CONSENT TO TREATMENT

I have read the document Psychologist-Client Service Agreement and Dr. Gina Madrigrano has explained to me the purpose of treatment, its risk and benefits, and I understand the limits to confidentiality, her approach to treatment, communications between sessions, and emergencies. We also discussed her fees, attendance, cancellation, and payment policies.

I understand the meaning of *Informed Consent* and agree to request clarification if I ever have any questions about the therapeutic process, procedures, possible risks, and anticipated outcomes.

I understand that I am free to stop psychotherapy for any reason at any time. I also understand that Dr. Gina Madrigrano may have to refer me to another practitioner if she deems that this is in my best interest.

Your signature below indicates that you have read the Agreement and agree to its terms. It also serves as an acknowledgment that you have received a detailed fee schedule, as described above.

_____ _____

Client's signature (or legal guardian) Date

_____

Printed Name

_____ _____

Dr. Gina Madrigrano Date
Psychologist