Tara Sharifan, PsyD
Licensed Psychologist

Busy Bee Pediatrics
520. E. Medical Drive # 301
Bountiful, UT 84010
801-292-1464

Informed Consent Agreement

I acknowledge that I have discussed and understand information regarding the therapy I am considering. The benefits of treatment have been discussed with me. I have had all my questions answered fully. I wish to be seen as a client for psychological services provided by Tara Sharifan, Psy.D.. These psychological services may include individual and family therapy and/or psychological testing.

I give my permission to Tara Sharifan, Psy.D. to observe and keep records of treatment contacts and sessions with me. I understand this information will be part of my electronic medical record at Busy Bee Pediatrics and available for my primary care provider to review in order to provide the best care. I understand email communication is not a secure form of communication and should never be used as a way to contact Dr. Sharifan in an emergency.

I understand that developing a treatment plan with Dr. Sharifan and regularly reviewing our work toward meeting treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or any procedure provided by Dr. Sharifan. Our goal as a primary care pediatric practice is to work on improving difficulties in less than 16 - 20 sessions and then transitioning to check ins 4-6 times a year, if needed. If long term weekly counseling were deemed necessary, I understand I would be referred to a more appropriate setting.

- ✓ I am aware that I may stop treatment with Tara Sharifan, Psy.D. at any time. The only thing that I will still be responsible for is paying for services that I have already received.

- ✓ I know that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel or do not show, I may be charged a fee for that missed appointment (if a third party is involved, their direction will be followed).

- ✓ I am aware that an agent of my insurance company or other third-party payer may be given extensive information about the diagnosis, progress, discharge, cost(s), date(s) and providers of any service or treatments that I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. Additionally, I understand that the therapist's billing agents will have access to my contact information, as well as dates and charges for services.

- ✓ I understand that I may not be able to reach my therapist at all times. In the event of an emergency, my alternative contacts are the 24 – hour phone number at Busy Bee Pediatrics and emergency services at a hospital.

Tara Sharifan, Psy.D. will protect the confidentiality of all materials related to my treatment except in the following situations:

1. If I give my written permission for information to be shared with another agency or person,
2. If my insurance company requests information regarding procedures and diagnoses necessary for billing purposes.
3. If there is a suspicion of neglect or abuse of a child or elderly person,
4. If I (or my child) threaten(s) to seriously hurt myself (him/herself) or someone else,
5. If my records are subpoenaed by court of law.

My signature below shows that I understand and agree with all of these statements.

Signed _____ Date _____
Name of patient (or patient signature)

Signed _____ Date _____
Signature of Parent, Guardian or Personal Representative (if applicable)

I, Tara Sharifan, Psy.D., have disclosed the issues above with the client (and his/her parent, guardian). My observations of this person's behavior and responses gave me no reason to believe that this person is not fully competent to give informed and willing consent.

Signed _____ Date _____
Tara Sharifan, Psy.D., Licensed Psychologist