

INFORMED CONSENT

For psychological counseling services

This document aims to provide clear and transparent information about the program we are about to embark on, so that the choice is made freely and consciously.

The undersigned, Cecilia Iacono, licensed to practice psychological counselling, before providing professional services to:

FILL IN THE INFORMATION BOX

Name and last name	
Place of birth	
Date of birth	
Address (via, n°, CAP, city)	
Codice Fiscale	
Phone number	
E-mail	
Emergency contact	
Family doctor's name and last name	

provides the following information.

Psychological counseling and support services will be provided at the offices in Via Michele Schina 15, Turin and/or Corso Piave 66, Alba and/or remotely if necessary on online platforms agreed upon with the patient.

The service may require the participation of other professionals, to be previously agreed upon with the patient.

In order to facilitate and monitor the progress of clinical work over time, data generated during the professional relationship may be collected in the form of medical records, including session

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Counselor, Psychologist, Psychotherapist in-training

notes and data and results from assessment tools. The data will be retained, including for legal and ethical reasons, for a period of five years after the end of the relationship. In accordance with the GDPR regarding the retention of sensitive data, they are stored securely and without third-party access.

The duration of the treatment, not being quantifiable in advance, will be commensurate with the needs of the treatment itself.

The following tools may be used to achieve the objectives: clinical psychological interviews, various types of psychodiagnostic tests, rating scales, etc. if and when necessary.

The meetings will last 50 minutes and it will be held weekly, biweekly, or otherwise depending on the agreements made verbally with the patient.

In accordance with Article 9, paragraph 6, of Law No. 27/2012, as amended by paragraph 150 of Law No. 124/2017, the agreed fee for each meeting is:

- 60 euros + 4% National Social Security Fund (ENPAP) ("VAT-exempt transaction pursuant to art. 10, paragraph 1, no. 18 of Presidential Decree no. 633/1972")

Payment will be made upon receipt of biweekly or monthly billing, unless other arrangements are made with the patient.

Please note that compensation cannot be contingent on the outcome or results of the professional intervention.

The estimated cost is formulated in relation to the scope of the work; it is presented in general terms, based on foreseeable circumstances and on information provided and available at the time of drafting this document. The estimate may be subject to changes, to be communicated in writing, if the services to be performed change from those initially envisaged or in accordance to the market.

In the event of the patient's absence without providing at least 24 hours' notice, the fee due will be equal to 100% of the agreed amount.

At any time, the patient may communicate to the professional their wish to interrupt the ongoing treatment, even with immediate effect. It is though recommended to have one final session to gather the journey outcomes and dissipate any remaining questions or doubts.

At any time, the professional may, with adequate notice, temporarily or permanently interrupt the treatment due to necessity and/or serious personal impediment, possibly indicating to the patient other professionals whose services he/she may avail of.

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The professional is required to comply with the Code of Ethics of Italian Psychologists.

The patient's personal and sensitive data, covered by professional secrecy, will be used exclusively for treatment purposes.

All material produced by the professional remains his or her exclusive property. Material produced during treatment by the patient will be returned upon request.

The undersigned declares to be insured for professional liability insurance under CAMPI policy.

Ms./Mr. _____ (name and last name) declares that he/she has understood the information provided by the professional and reported above, and has fully decided to avail him/herself of the professional services of Dr. Cecilia Iacono as described above. Having received specific information on the processing of personal data, he/she

- ☐ provides consent
☐ does not consent

to the treatment.

Place and date _____

Signature _____