STACY THOMAS, PH.D., C.PSYCH

Your signature below indicates that you have read the information in the CONSENT FOR PSYCHOLOGICAL SERVICES and the PRIVACY POLICY documents and agree to abide by its terms during our professional relationship. Please print and complete this page and bring it with you to your first appointment.

Patient Name: _____

Patient Signature: _____ Date:_____

Psychologist/
Psychotherapist Signature:_____ Date: _____

AUTHORIZATION FOR EMAIL COMMUNICATION (optional)

I acknowledge that I have read and fully understand the risks associated with communication by email between Stacy Thomas, Ph. D., C. Psych., (including her associates) and me and consent to the conditions outlined as well as any other instructions that Stacy Thomas, Ph.D., C. Psych and her associates may impose to communicate with patients by email. I acknowledge the right of Stacy Thomas, Ph.D., C. Psych and her associates to withdraw the option of communicating through email. Any questions I may have were answered.

Patient Name: _____

Patient Signature: _____ Date:_____

Psychologist/
Psychotherapist Signature:_____ Date:_____

STACY THOMAS, PH.D., C. PSYCH
College of Psychologists of Ontario Certificate #4082
625 Queen St. East, Suite 108, Toronto, ON, M4M 1G7
tel: 647-478-9297 fax: 647-689-2365
dr.stacy@bell.net drstacythomas.com