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**Informed Consent for Psychological Testing**

Please read this document carefully in its entirety and ask any questions you have about the content. When you sign this document, it will represent an agreement between us.

CREDENTIALS: I hold a Master’s degree in School Psychology and am Licensed as an Educational Psychologist by the California Board of Behavioral Sciences (License #\_\_\_\_\_)

PRACTICE STRUCTURE: I am in independent practice and am not affiliated with any other individual or practice. My professional records are securely maintained and can only be shared or accessed with your specific written permission.

WHAT IS PSYCHOLOGICAL TESTING? Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and use of a variety of standardized measures in two or more appointments. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include measures of:

* Cognitive Ability
* Academic Achievement and Learning Progress
* Attention, Executive Functioning, and Memory
* Visual and Auditory Information Processing
* Motor and Visual Perceptual Abilities
* Behavioral and Emotional Functioning

WHAT IS THE PROCESS? Prior to the assessment, please complete intake paperwork and rating scale information that has been shared with you. The in-person psychological assessment is typically completed over 2 to 3 appointments with an additional feedback session completed in person or via video conference to review the results and recommendations.

USE OF THE EVALUATION REPORT: After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals including but not limited to the school team, the pediatrician and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place. Please be aware that it is not in my control whether the school will agree to implement the recommendations. The recommendations will be practical, driven by the test data and relevant to the needs of your child in the context of the evaluation results.

FEES AND PAYMENT: A $200 non-refundable deposit is required at the time the appointment is scheduled. The remaining fees will be split between a ½ installment at the first day of testing and the remainder at the feedback session. A complete psychological evaluation involves the initial appointment, preceded by scoring and interpretation of written questionnaire measures sent in advance of the first appointment, followed by face-to-face testing measures with the examiner, usually over two to three appointments. Testing also involves scoring and interpretation of the results and the preparation of an integrative written report. The writing of the report usually takes at least as many hours as and often even more hours to complete than the testing time itself. Total cost of Psychological assessment and fee schedule can be found on the Assessment Plan Agreement Form.

INSURANCE INFORMATION: I am an out-of-network provider. This means that I am not a member of a provider network for any managed care plans. Your insurance plan may or may not cover visits to an out-of-network provider. You are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. I will provide you with a Statement for Reimbursement/Superbill should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services and many require the member to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment. If you call your insurance company, let them know that you are calling for “preauthorization for psychological testing.” They may ask you for CPT Codes. These are listed below:

96130, Psychological Testing, first hour

96131, Psychological Testing, each additional hour

If your insurance company authorizes the testing, they will use the date they receive the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of forms that I submit so that you can follow up with them directly.

CANCELLATION POLICY: If you must cancel an appointment, please give a minimum of 24 hours advance notice. If this minimum is not provided, you will be charged a cancellation fee of $ 100 for the initial appointment or family feedback meeting and a $ 200 fee for the cancellation of a testing appointment. Given the large amount of reserved time made available to you for testing appointments, short notice cancellations for the testing sessions may result in the cancellation of subsequent appointments and loss of $200 deposit.

CONFIDENTIALITY: All information disclosed in sessions is confidential and may not be revealed to anyone without the client or guardian’s written permission, except where disclosure is mandated or allowed by law. Such situations include the following:

* The evaluator believes that a client may be a danger to themself, another, or another’s property and that disclosure is necessary to prevent the danger. In the case of danger to another, the psychologist is required to notify the police and take reasonable steps to warn the intended victim.
* There is a reasonable suspicion of actual or potential child abuse (emotional, physical, sexual) or neglect involving the client, or someone known by the client.
* There is a reasonable suspicion of neglect or abuse of a dependent adult or elderly person.
* A client is “gravely disabled” (i.e., is unable to take care of basic needs such as feeding, self-grooming, getting home safely).
* A valid court order (legal subpoena) is issued for a client’s files.

**Patient’s Bill of Rights**

* Request and receive full information about the psychologist’s professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
* Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
* Receive respectful treatment that will be helpful to you.
* A safe environment, free from sexual, physical, and emotional abuse.
* Ask questions about your therapy.
* Refuse to answer any questions or disclose any information you choose not to reveal.
* Request that the therapist inform you of your progress.
* Know the limitations of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
* Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
* Refuse a particular type of treatment or end treatment without obligation or harassment.
* Refuse electronic recording (but you may request it if you wish).
* Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.

CONTACT: The best way to contact the evaluator is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24-48 hours, except for weekends and holidays, but cannot guarantee that this is always possible.

If you are facing a psychological or medical emergency call 911.

AGREEMENT OF INFORMED CONSENT: Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

* You have been informed of and understand the type of services to be provided.
* You have been informed of the limits of confidentiality.
* You understand and agree to the payment and cancellation policies.
* You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
* You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Name of individual receiving psychological assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature Date