Kathy Khoie, Ph.D.
Psychologist PSY21243
(818) 743-0102

CONSENT FOR PSYCHOLOGICAL EVALUATION

I, --, authorize Dr. Khoie to conduct a psychological

evaluation for: --.
Name of Client (self, child, other)

Please read:

Limits of confidentiality: Please note the information that you provide to Dr. Khoie will be used for the purpose of your psychological evaluation and may be indicated in your psychological report. If you are referred for an assessment by your insurance company, a copy of the report will be submitted to your insurance company. Otherwise, the information you provide with Dr. Khoie is strictly confidential and will not be shared without your consent. Please note that psychologists are mandated reporters and have a duty to warn and protect. The law limits this agreement, and expects that any serious threats of harm to self or others as well as suspicion of child or elder abuse will be reported to the appropriate authorities. If you have any questions, please feel free to discuss them with Dr. Khoie. Thank you.

Cancellation policy: Please note that Dr. Khoie has a 48 hours cancellation policy. There will be a $100 charge for no shows, or appointments cancelled with less than 48 hours notice.

Payment policy: Payments are due in full prior to scheduled services (unless other arrangements have been made).

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

______________________________ ______________________________
Name of Client Name of Parent/ Legal Guardian/ Attorney

______________________________ ______________________________
Signature of Client / Parent / Legal Guardian/ Attorney

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Date