**Pre-Surgical Psychological Evaluation Consent**

***This Psychological Evaluation is being conducted at the request of:***

Therefore, it may be different from other psychological/healthcare services. It is important for you to understand how a pre-surgical psychological evaluation differs from more tradition psychological evaluations.

***This evaluation is specifically for the purpose(s) of:***

While the results of this evaluation may or may not be helpful to you personally, the goal of this evaluation is to provide information about your psychological functioning to the individual(s) or agency requesting the evaluation for use in determining your eligibility for the procedure listed above. The purpose of the evaluation is for a medical procedure. As such, the confidentiality of the evaluation and the results therein, is determined by the rules of that system. *Traditional doctor-patient confidentiality rules do apply*. If your physician/surgeon has requested this evaluation, he/she alone will receive a signed copy of my report. You may request a copy of this report directly from your physician/surgeon. However, you will control how it is to be used and/or who will have access to it if used for purposes other than listed above.

*Typically, the results of this evaluation are protected by the doctor-patient privilege, and will not be broken without your signed consent. However, exceptions to this rule could and do include:*

* A determination on my part that you present an immediate danger to yourself or another person
* You reveal information that a child has been, or is being abused
* A court of law orders me to do so

There may be other examples where the law requires me to release the information obtained during the evaluation. We will discuss these situations if they arise, on a case-by-case basis.

Your participation in this evaluation is voluntary. I will not conduct the evaluation without your consent, payment and signature on this document. You also have the right to stop the evaluation at any time. There may be medical, legal or other consequences if you stop the evaluation; therefore, it would be in your best interest to consult with your physician/surgeon before doing so.

The cost of this evaluation service, including all interviews, testing (if conducted) and report writing is ***$300.00***. The fee is due in-full upon signing this consent, and reports cannot be released prior to receiving payment in full. Any additional services, which may arise as a result of this evaluation, or at any time following the completion of the evaluation, are not covered by this fee and will be charged at the rate of $150.00 per hour as necessary and/or requested by you. We do not bill insurance providers for this service, or any necessary services following this evaluation, but will be happy to provide you with a “superbill” (upon request) which you can use to seek reimbursement directly from your insurance carrier. Please discuss payment options with me directly.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, understood and consented to all aspects of this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed (if relevant)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Payment of $\_\_\_\_\_\_\_\_\_\_ was made on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_by way of\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you,

**Medical Psychology Associates**

Dr. Scott D Wylie

Dr. Katherine Combs

**The practice of licensed psychologists in Colorado is regulated by:**

Department of Regulatory Agencies

Mental Health Section

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