



Consent for Psychological Testing & Evaluation

In signing this form, you agree to allow Weber Psychological to perform the following services:

- Administration of psychological testing or psychological batteries
- Administration of neuropsychological testing or batteries
- Administration of developmental-behavioral testing (Autism, behavioral, and developmental disorders)
- Completion of a hard-copy psychological report
- Other (describe): _____

You understand that you are financially responsible for all services provided. If a preauthorization is required by your health insurance company, you understand that coverage is not guaranteed. Payment for non-insurance covered services is expected at the time of each appointment. Should you need to finance the cost of the non-insurance covered services, arrangements can be made prior to your appointment via an agreed upon payment plan. Such plans should be discussed and agreed upon prior to the initiation of any evaluation. Assessment and evaluation services may include administration of inventories, or may include scoring and interpreting any testing protocols, collaboration with other professionals and associated providers, and follow-ups with the client to deliver and explain the findings/results. You acknowledge that you have been provided with a Notice of Privacy Practices as it pertains to our use and disclosure of your personal health information (PHI). This notice, which is attached to this consent form, explains HIPAA and its application to your PHI in further detail.

I acknowledge that the fee for evaluation and assessment service(s) has been discussed with me, and I have set forth the following arrangement for payment of such services:

- Insurance pay; Name of insurance carrier: _____
ID #: _____ Group #: _____ Plan: _____
Member Name: _____ DOB: _____
- Self-pay; paid in full
- Self-pay; payment plan arranged: _____

You acknowledge that the final report for your evaluation will not be given to you until all payment has been made on your account. This includes all deductibles set forth by your insurance company as well as co-payments for visits. I understand that a credit card will be kept on file for all payments left outstanding.

The purpose(s) for the proposed evaluation is:

1. _____
2. _____
3. _____

Your evaluator, a licensed clinical psychologist, is responsible for selecting the inventories best suited for the evaluation, based upon the referral questions and concerns. All evaluation procedures which include inventory selection, administration, scoring, interpreting and safekeeping of the results are carried out in accordance with the rules and guidelines of the American Psychological Association, the Health Insurance Portability and Accountability Act (HIPAA) and State of Pennsylvania regulations for psychological services.

You have the right to terminate evaluation services for any reason, though payment may still be expected for services already rendered.

Your signature below confirms that you have read and agree to terms outlined above. Your signature also serves as an acknowledgement that you have received the HIPAA notice form regarding our privacy practice.

Signature of client (or parent/guardian)

Date

I, the evaluator, have discussed the consent for evaluation services with the client (and/or the parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of evaluator

Date