

## Testing Consent Form

Welcome to SBS Psychological Associates, Inc. This form will provide information about our testing and evaluation services. Please be sure to discuss any questions with your clinician. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you to SBS for this assessment. These questions generally concern learning disabilities, academic functioning, personality functioning or coping styles. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations and recommendations.

The assessment process generally involves an informational interview followed by the administration of one or more educational and/or psychological tests. Although it is sometimes possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed. During a meeting with your clinician feedback will be provided to you, and you will have the opportunity to discuss the results, and ask questions. Our general turnaround time for completed reports is between 2 to 4 weeks.

### CONFIDENTIALITY

The information obtained in this evaluation is confidential and will not be released to any person or organization without your written permission. The only exceptions to this policy are rare situations in which we are required by law to release information with or without your permission. These are: 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if we judge that you are in danger of harming yourself or another individual; 3) if your records are subpoenaed by the court; and 4) if you were referred by a third party, such as Department of Family and Children Services or Department of Juvenile Justice. Under such circumstances, we would attempt to discuss our intentions with you before an action is taken, and we would limit disclosure of confidential information to the minimum necessary for the purposes of the evaluation.

If you are sending your statement into your health insurance to cover the cost of this assessment, you should be aware that the insurance company will require a diagnosis and sometimes additional information before authorizing payment. Since this information would become a part of your insurance file, you may wish to check with your insurance carrier to be sure you are comfortable with the nature of the information that may be requested prior to authorizing billing.

**REQUEST FOR INFORMATION**

For reasons pertinent to the referral question, we sometimes like to gather data from your doctors (primary care physicians or mental health professional). Please indicate your preference regarding contacting these individuals, and provide their mailing addresses.

Yes, you may contact my doctor(s): \_\_\_\_\_

Contact Information: \_\_\_\_\_

No, please do not contact my doctor(s).

**COMMUNICATING RESULTS**

Circle or add other people or systems that should receive test results. Further, your signature below indicates that only results specific to the referral question will be communicated.

Current School    Future School    Other(s): \_\_\_\_\_

**Signature:** \_\_\_\_\_

**FEE AND PAYMENT POLICY**

The standard fee for a testing battery at SBS varies, depending on the question to be answered or the reason for the testing. The fee may be adjusted at times depending upon the purpose of the evaluation and the tests used. Although we will bill your insurance for the testing fee, your insurance may decide that testing is not needed at this time, limit the amount of testing believed needed or decide to only reimburse a portion of the fee. If this should occur we will discuss your options for proceeding with testing, including your financial responsibility for any testing that you decide to pursue. Many individuals chose to pay out of pocket rather than use their insurance to avoid releasing sensitive or confidential information to their insurance company. Most often this is due to concerns about privacy or protected information.

We accept most credit and debit cards. Questions concerning the fee or the payment policy should be discussed with your clinician before the assessment process begins.

I am aware that full payment for the assessment must be made in full no later than the last day of testing. **Please Initial:** \_\_\_\_\_

**AGREEMENT**

I have read the above material, and I fully understand my rights and obligations as a client of SBS Psychological Associates, Inc. I freely agree to this assessment.

\_\_\_\_\_  
Name of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Client or Parent/Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician's Signature Date

\_\_\_\_\_  
Date