INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and consent to psychological services provided by the undersigned psychologist. This consent applies to myself, child, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

LIMITATIONS OF SERVICES

I understand that psychological services are limited to psychological evaluation, assessment, consultation, and intervention. I understand that evaluation and assessment services may also include the use of psychological and neuropsychological tests. I understand that intervention services may include counseling and psychotherapy. I understand that the undersigned psychologist is not warranting a cure or offering any guarantee of results or improvement of any condition.

Initial here if this section has been read and understood _____

ASSUMPTION OF RISKS

I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion and an increased understanding of myself. I understand that potential risks may include limited predictive validity of psychological assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another psychologist, psychiatrist, or mental health professional.

Initial here if this section has been read and understood _____

LIMITS OF CONFIDENTIALITY

I understand and agree that my disclosures and communications are considered confidential and privileged, except to the extent that I authorize a release of information, or under certain other conditions listed below. Mental health professionals may disclose confidential information without the consent of the client in order to (a) provide professional services, such as counseling, psychotherapy, and psychological testing; (b) operate a professional practice, such as handling phone calls and scheduling appointments through office staff; (c) obtain peer consultations with other professionals, although peer consultations do not require disclosure of the identity of a client; (d) obtain payment for services, including the filing of insurance forms and mailing statements of accounts; (e) comply with mandated reporting requirements in situations in which abuse or neglect of a child, elderly person, or disabled or vulnerable individual is reasonably suspected; (f) protect the client/patient, practitioner, or others from harm or imminent danger, including situations in which an immediate threat of physical violence against a readily identifiable victim is disclosed to the practitioner; (g) comply with legal requirements in the context of civil commitment proceedings, including situations in which an imminent threat of self-inflicted damage is disclosed to the practitioner; (h) comply with legal requirements such as court orders, including situations in which the client/patient is examined pursuant to a court order; and (i) provide a defense in situations in which such information is necessary for the practitioner to defend against a disciplinary board complaint or malpractice action brought by the client/patient. I understand that it is possible that confidential and privileged information may be released without my consent or authorization in the aforementioned circumstances, although in such cases the disclosure of confidential information is limited to the minimum that is necessary to achieve the purpose. I hold the undersigned psychologist harmless for releasing information under any of the above conditions.

Initial here if this section has been read and understood _____

RELEASE OF INFORMATION

I understand that my records may be protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the

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regulations. By authorizing a release of information, I understand that I am waiving the confidential nature of the client-psychologist relationship. I authorize the release of information as necessary for the purpose of the undersigned psychologist obtaining consultation regarding my evaluation or treatment. If I am being treated in a hospital or by a treatment team, I understand and agree that the undersigned psychologist may discuss my evaluation and treatment with my physician, hospital staff, treatment team, utilization review staff, and others concerned with my care. I authorize the release of any and all information requested by my managed care company, insurance carrier, or third-party payor for the purpose of processing my insurance claim and obtaining payment for services. By authorizing the release of information to an insurance company or other third party, I understand that the information may become part of the third party's records and that the undersigned psychologist can no longer control any subsequent release of that information. The undersigned psychologist has informed me that should I ever authorize a general release of my medical records to or from an insurance company or other third party, it is possible that the third party's copy of my psychological records could possibly be released by the third party without the undersigned psychologist's knowledge. I understand that the undersigned psychologist cannot prevent any hospital, physician's office, insurance company, or others from releasing or redisclosing information to the Medical Information Bureau (MIB, Inc.) or other agencies or persons. I hold the undersigned psychologist harmless for any secondary release or redisclosure of my report made by the hospital, physician's office, insurance company, medical information bureau, or any person or agency to whom the report is originally released. After giving consideration to the extent of this release, I specifically direct and authorize the undersigned psychologist to exchange confidential information and discuss his or her opinions with the following agencies or persons named below for the purpose of providing information about my evaluation or treatment:

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_____

_____

(Individuals or organizations to whom information may be released)

Initial here if this section has been read and understood _____

STATEMENT OF UNDERSTANDING

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically as follows: I understand that my consent for release of information will be considered valid for twelve (12) months following the date below. I acknowledge that I voluntarily consent to the above conditions and that this consent form is valid during any related claims. I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction, all blank spaces on the form have been completed, and all statements of which I do not approve have been stricken. By signing this form, I understand and agree with the terms and conditions of this form.

_____ _____

Client's Signature Date

_____ _____

Practitioner's Signature Date