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INFORMED CONSENT FOR EVALUATION/ ASSESSMENT SERVICES

I _____ (patient), _____ (parent/guardian) understand evaluation/assessment services are intended to produce an objective account of the patient's psychological, neurodevelopmental or neuropsychological functioning depending on the nature of the referral question. To this end, a patient may not expect a report to be written or edited in a manner that is not reflective of this evaluator's impressions of the data collected. However, information will be presented in a manner understandable tothe patient/payer and in the best interest of the patient.

Depending on the nature of the referral question, an evaluation may address psychological, intellectual, socioemotional, developmental or neuropsychological functioning. An explanation of the applicable testing procedures and instruments can be provided to the patient/payer prior to beginning of testing/interviews. The patient/payer is responsible for clarifying any questions regarding procedures of testing, content to be covered or materials to be used in the evaluation.

Evaluation results are confidential and under most circumstances will only be released to those persons authorized by the patient/parent/guardian. While in general, information obtained in an evaluation is confidential there are several exceptions to this privilege. State and federal laws require the reporting of any knowledge or suspicion of incidents of physical or sexual child abuse. Similar legal precedents concern threats of violence made by clients in sessions and the therapists' duty to warn the authorities as well as the intended victim. In addition,should your records be subpoena by a judge's court order, they may be subject to release to the courts.

The patient/payer signature here indicates that he/she understands the nature of evaluation services including procedures, content, and assessment materials to be used. Your signature below as the patient/payer indicates that you have read the above Informed Consent for Evaluation/Assessment and agree to participate/pay for evaluation/assessment services.

Name of Patient:	Name of Parent/Guardian:
Signature of Parent/Guardian:	Date:
Signature of Gale & Associates Rep.:	Date: