

Consent and Agreement for Psychological Testing and Evaluation

I acknowledge that I have received, have read (or have had read to me), and understand the “Information for Clients” brochure as well as the HIPAA forms. I have had all my questions fully answered.

I, _____, agree to allow the psychologist named below to perform the following services:

- ____ Psychological testing, assessment, or evaluation
- ____ Report writing
- ____ Consultation with school personnel
- ____ Consultation with lawyers
- ____ Deposition (that is, written testimony given to a court, not made in open court)
- ____ Testimony in court
- ____ Other: (describe) _____

This agreement concerns _____.
Client name

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist’s time for the reading of reports, consultation with other psychologists and professionals, scoring of tests, interpreting of results, and any other activities to support these services.

I understand that I am fully responsible for payment for these services.

I agree to help as much as I can, but supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

I know that I must call to cancel an appointment at least 72 hours (3 days) before the appointment time. If I do not cancel and do not show up, I will be charged for that appointment. I agree to pay for uncanceled appointments or those where I fail to give enough notice that I will not attend. The only exceptions are unforeseen or unavoidable situations that arise suddenly.

My signature below shows that I understand and agree with all these statements.

Signature of client or client guardian

Date

Printed Name

Relationship to client
(if necessary)