Tracy R. Zemansky, Ph.D.
Courage to Change, Inc. Psychological Assessment and Psychotherapy

CONSENT FOR PSYCHOLOGICAL EVALUATION and/or TESTING

Dear Client,
Welcome to my office. Please take time to read my office polices and consent for psychological testing form. If you have any questions about this form or any other aspect of psychological evaluation and/or testing, please feel free to ask me before we begin or at any time during our work together. This form will provide information about my services and about your rights and responsibilities as a client. Your signature at the bottom of this form indicates that you understand the information and freely consent to participate in this assessment.

TESTING:

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you for this assessment. These questions generally concern diagnostic questions, academic functioning, personality functioning, relationship and family functioning, addictive/compulsive issues, 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 some assessments do not involve any testing. While 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 and a report or letter of the results will be written. In most cases, you will then have the opportunity to meet with me to discuss the results and receive a copy of the report or letter. My general turnaround time for completed reports is about 4-6 weeks.

There is a therapist on call during non-office hours for emergencies only. Please leave a message on the answering machine for any other type of scheduling changes. If you have not heard back from me within 24 hours, please call back. Be certain to leave your telephone number, even if you think I have it. I normally do not do therapy over the phone; however, if a crisis arises and you need assistance, I will be glad to talk with you.

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 I am 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; and 3) if your records are subpoenaed by the court. In the rare event of any of these situations, 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 to insure safety.

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 family members, colleagues, close friends, and - with children - custodial parents. We will have you sign Release of Information forms for any person we may need to contact.

COMMUNICATING RESULTS:

Please note which people or systems that should receive these results. In order for me to send results to anyone else, or to discuss your testing process and results with anyone else, you must sign a specific Release of Confidential Information Form, and provide me with the specific names and addresses for those requested. Your signature at the end of this Consent form indicates
that only results specific to the referral question will be communicated.

Treatment Facility Physician Custodial Parent(s) Family Member
Court Attorney Current School Future School
Other Psychologist/Therapist/Psychiatrist/Mental Health Professional/Medical Professional

Name/s: _____
_____
_____

FEE AND PAYMENT POLICY:

The standard fee for a testing battery varies depending upon the purpose of the evaluation and the tests used. I do not bill insurance companies. We ask that you pay a retainer, generally this is half of your full estimated fee) prior to your initial appointment unless other arrangements have been made in advance. If your testing is being paid for by someone else or the Court, this must be documented in writing by an authorized person, prior to your first appointment. A minimum of one week notice for all cancellations for testing or evaluations or re-scheduling requests is required, or a fee of $1000.00 will be taken from the retainer monies. Questions concerning the fee or the payment policy should be discussed with me before the assessment process begins.

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I understand that I am personally responsible for payment of a standard hourly fee ($ 330.00) even if I arrive late or miss an appointment. _____ (initial here to show you agree to this policy).

Agreed to Fee/Adjusted Fee: $ (As Discussed/To Be Discussed)

Thank you for your cooperation with these policies. If you have any questions or concerns regarding the above, please feel free to discuss them with me. I look forward to working with you for Psychological Testing and to helping you achieve your personal goals and growth through this process.

AGREEMENT:
I have read the above material, and I fully understand my rights and obligations as a client with Dr. Tracy R. Zemansky. I freely agree to this assessment.

_____
Name of Client

_____
Signature (Client) and Date/Time

_____
Signature (Parent/legal guardian) and Date/Time

_____
Therapist Signature and Date/Time

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