**CONSENT AND AGREEMENT FOR PSYCHOLOGICAL TESTING AND**

**EVALUATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow the psychologist to perform the (Name of client/parent if minor) following services:

\_\_\_\_\_\_\_\_\_\_Psychological testing, assessment, or evaluation

\_\_\_\_\_\_\_\_\_\_\_\_\_Neuropsychological testing, assessment, or evaluation for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Name of client)

**Testing involves:**

I understand that these services may include: a review of previous records, direct, face-to-face contact, clinical interviews, gather additional information from school/employer (with written permission), as well as formal testing. These services will also include psychologist’s time for the reading of records, the scoring and interpretation of the test results, writing of the report and any other activities to support these services.

**Purpose of Testing:**

I understand that the purpose of this evaluation is to : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The length of time between will vary with each client.

The procedures for selecting, giving and scoring the tests, interpreting and storing the results, and maintain the privacy of the test results will be carried out in accordance with the guidelines of the American Psychological Association.

The tests will be chosen based on the suitability for the purposes aforementioned. These tests will be given and score according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific finding and guidelines from the scientific and professional literature.

The raw data, test results and report will be kept in a locked filing cabinet.

I understand that the fee for this (these) service(s) will be $\_\_\_\_\_\_\_\_\_\_\_\_. Payment for these services will be as follows:

* Bill my insurance company directly for these services. I agree to pay any deductibles, co-payments or other balance in accordance with my health insurance policy and in accordance with the contract (if any) between the psychologist and the health insurance company, I understand that I am fully responsible for payment these services at the contracted rate established by my health insurance.
* Pay in full. I understand that I am fully responsible for payment for these services.
* Set up payment plan with Agave Studio for Psychotherapy and Spiritual Direction. I understand that I am fully responsible for payment of these services.
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
If minor, signature of parent/guardian Date

I, the psychologist, have discussed the issue above with the client (and/or his or her parent or guardian). My observations of this person’s behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Psychologist / Date