Child/Teen Psychological Assessment
Informed Consent Agreement

Psychological Testing (Minor) I understand that in order to administer psychological testing, there must be a clear understanding and agreement about confidentiality, the licensed professional's role, procedures and fees. I understand that the licensed psychologist, Dr. Julia Rahn, Ph.D., and/or a *Studio For Change*® psychtechnician directly supervised by the licensed psychologist, Dr. Rahn, will administer all tests and procedures, analyze all test data, and prepare a report of her findings and recommendations. I agree that all test materials, results, and reports are the property of *Studio For Change®.*

Confidentiality
I acknowledge that Psychological Assessment is a complex task that requires information to be collected from a variety of sources. I understand that data from psychological tests must be analyzed in context, which requires the assembling of both current and historical information. I recognize that the context of a person may include information about development, health, education, family, personal interests and relationships.

I understand that information collected as part of the assessment process is confidential; information is shared only with those who are authorized to have access. I understand that the assessment process almost always includes the production of a written report which documents test data and places it in historical and developmental context. I acknowledge that reports written for this purpose are marked as confidential and will only be released to parents, guardians, and any other authorized individuals.

I understand that all of the information collected in the assessment process is kept secure. I recognize that the licensed professional, Dr. Rahn, employs reasonable and prudent procedures to protect the security of test data and reports. I understand that test reports and test data are released only with my authorization or in response to a subpoena.

I acknowledge that there are exceptions to confidentiality that are recognized by law. I understand that if the licensed professional, Dr. Rahn, believes my child is threatening serious harm to another person, she is required to try to protect the other person or persons. I recognize that in such a case, Dr. Rahn may have to tell the intended victim and the police and/or seek my child's hospitalization. Similarly, if my child threatens or acts in a way that is very likely to harm himself/herself, I understand that Dr. Rahn may have to seek hospitalization for my child, or contact my family members or others who can help to protect my child. I recognize that if such a situation arises, Dr. Rahn will discuss the situation with me as guardian before she contacts anyone else, unless matters of safety overrule such a discussion.

I understand that if Dr. Rahn believes or suspects that a child, an elderly person, a disabled person or anyone else is being abused due to my neglect, assault, battery or sexual molestation, that she is bound by law to file a report with the appropriate agency. I understand that she does not have any authority to investigate the situation after it is reported, and that her report may trigger an investigation by the agency. I understand that there are additional ways confidentiality may be limited, and that it may be necessary to talk about my child's treatment with other professionals. I acknowledge that my child's name will not be revealed, and I understand that the other professional is also legally bound to maintain the confidentiality of my child's information.

I am aware that psychological evaluations are confidential, yet can become quasi-public documents. I understand that I will see and read the report of my minor child's evaluation. I acknowledge that other professionals or doctors, and/or a school may obtain a copy of the report, and that many individuals may know the results of psychological testing. I understand that Dr. Rahn will always attempt to be discreet and maintain confidentiality within the limits of the nature of this testing arrangement, though once a report is released, I accept that Dr. Rahn will have no control over its use or dissemination from that point forward.

I understand that children who are under the age of 12 (approximately) have limited legal rights with regard to confidentiality. I recognize that the younger the child, the more appropriate it is for Dr. Rahn to inform parents about what a child may have divulged to her during the evaluation. I am aware, however, that as a child becomes better able to understand and choose (typically between the ages of 12 and 18), he or she assumes legal rights. I acknowledge that in the process of collecting information from an adolescent, there are gray areas and that some teens may not share certain information with Dr. Rahn unless she promises a significant degree of confidentiality. I understand that to better understand the dynamics of my child, Dr. Rahn may choose to leave certain information out of a final report. I am aware that a common area of difficulty is drug use and that my child may have denied aspects of his or her use to me as a parent, but may be more forthcoming in the evaluation to Dr. Rahn. I accept that Dr. Rahn will use clinical judgment to decide the importance of specific information and its inclusion in the report. I understand that there are times when a decision is made to inform parents and others about information obtained from an evaluation that my child would rather remain confidential.

I understand that other issues such as pregnancy, abortion, illegal activities and sexual orientation also represent gray areas where a clear-cut set of rules regarding confidentiality does not always apply. I acknowledge that the discussion of whether or not to divulge a specific circumstance remains confidential. I recognize that it is always Dr. Rahn's intent to persuade a child or adolescent to not keep secrets. I understand that once an adolescent has had his or her 18th birthday, even if in high school and still living at home, he or she may evoke complete confidentiality over any element of an evaluation.

By reading the above information, I am aware that the laws and rules on confidentiality are complex and often do not appear to apply to every situation. I understand that if I have questions about confidentiality, I should discuss them with Dr. Rahn or an attorney. I understand that while complications not addressed here occur infrequently, Dr. Rahn is not able to give me legal advice. If my child or I have special or unusual concerns and need more specific advice, I agree to talk with an attorney to protect my interests legally.

Release of Information and Records

I understand that Dr. Rahn will maintain all notes, documents and test data in a safe and proper manner in accordance with applicable laws for the state of Illinois. I understand that copies of the final report are released only to those individuals whom I designate. I accept that the final report may be delivered to authorized individuals in a variety of ways including: printed copy sent by mail, facsimile or digital copy; when a digital copy is sent, it will be sent encrypted as a *Certified Mail* (e-mail) product.

I understand that in most cases, a report will be the final product of this assessment process. I understand that clerical staff may help organize materials and assist Dr. Rahn with clerical tasks. I understand that this individual has signed a confidentiality agreement and provides clerical/administrative support only.

I agree to sign any and all releases necessary to obtain reports or information from others who may supply relevant data (including but not limited to: psychiatrists, psychologists, therapists, teachers, school officials, pediatricians, etc.).

Fees and Payment

I acknowledge that psychological assessment is a specialty and may only be performed by individuals with the proper training, experience and license, and that typically this person is a licensed psychologist or someone supervised by a licensed psychologist. I understand that due to the special training, materials, and skills required, psychological assessment is expensive, and rarely covered by insurance. I acknowledge that preauthorization may be required by my insurance company, and it is my responsibility to obtain such preauthorization prior to the start of the assessment.

I acknowledge that psychological testing involves face-to-face assessment procedures, typically administered in a private office and often involving several hours over three or more sessions. I understand that psychological testing also involves scoring and interpreting test results and the preparation of a written report, and that these tasks often take as many hours to complete as the time spent face-to-face with the client. I recognize that a number of tasks can add to the cost of an assessment: home visits, review of documents such as prior reports,

collateral contacts with individuals (parents, teachers, therapists or doctors, etc.), and the administration of special test procedures to better identify a specific problem or need. I understand that costs may also be increased for urgent or emergency responses or cases when the time required to produce a report is critical.

I am aware that the total cost for a full battery of testing ranges from $2,500 to $3,500 and is billed at $250.00 per hour. Unless using BC/BS insurance, a deposit of $700 is due at the first session. A credit card will remain on file to bill the acquired fees including balance remainder, copays, coinsurance and/or deductible amounts. Payment plans may be utilized in agreement with the licensed psychologist and the person financially responsible for the account. I understand that complete payment of the balance must be submitted prior to my receiving the written report (credit card on file is sufficient when using BCBS insurance). I understand that Studio For Change® accepts payments by check, cash and credit card.

Regarding payment, I agree that in consideration for services provided, I am obligated to pay for all services billed by Studio For Change® including those billed and not covered by insurance. Shall the account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expense. I understand that all delinquent accounts are subject to delinquency fees.

I understand that if my account with Studio For Change® is unpaid and overdue without an arranged payment plan, legal means may be used to obtain payment from me. The only information given to the court, a collection agency, or a lawyer would include my name, address, the dates of professional services, and the amount due.

I understand that the person(s) designated as financially responsible for the account will be provided with an itemized receipt following the release of the final report. I am aware that this receipt will include confirmation of my initial deposit and final payment, and that it will be itemized and will correlate charges with appropriate CPT codes.

Complaint procedures
I recognize that Julia Rahn, Ph.D. is a licensed clinical psychologist who is voluntarily following APA ethical guidelines. I acknowledge that if I am dissatisfied with any aspect of the assessment process, I will discuss any issues with Dr. Rahn immediately. I understand that if I believe that I have been treated unfairly or even unethically and cannot resolve a problem, I can contact the Illinois State Board of Professional Regulation from whom Dr. Rahn receives her license to practice as a Psychologist.

I have read the material above, discussed it with my attorney (if necessary), understand it, and agree to participate as outlined.

_____
Child's Name

_____ _____
Signature of parent / guardian Date

_____
Printed Name and Relationship