Emily Brown Werner, PhD

Licensed Clinical Psychologist

1800 30th Street, Suite 305

Boulder, CO 80301

Phone/Fax: 303.233.4186, Ext. 2

**Disclosure and Consent for Psychological Testing and Evaluation**

DISCLOSURE

* My education and training:

Degrees: B.A. (1992) Washington University, Psychology

 M.A. (1998) University of Washington, Child Clinical Psychology

 Ph.D. (2002) University of Washington, Child Clinical Psychology

Clinical Internship: (2001-2002) University of North Carolina Medical Center

License:  Licensed Psychologist, Colorado Board of Psychologist Examiners (3213)

* The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.
* As to the regulatory requirements applicable to mental health professionals**:**
	+ A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
* You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.
* In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
* Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse or serious threats to harm another to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

CONSENT FOR EVALUATION

In order to provide the best possible assessment for your child, it is critical that we work collaboratively and that you understand and agree to the following:

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow Emily Brown Werner, PhD, Licensed Clinical Psychologist, to perform psychological testing, assessment, or evaluation, including report writing for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist’s time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, report writing, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.
* I understand that the fee for these service(s) will be $ \_\_\_\_\_\_\_\_\_, and that this is payable in two parts: a deposit of $\_\_\_\_\_\_\_\_ payable before the start of these services, and a second payment equal to the balance due on the completion of testing. I understand that I am fully responsible for payment for these services. I understand that Dr. Werner does not bill insurance, but will provide me with an itemized receipt should I wish to submit it to my insurance company or medical flex spending plan.
* In the case of divorced or separated parents with joint decision making, I attest that both parents are in agreement about proceeding with this evaluation.
* I also understand that Dr. Werner agrees to the following:
1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations and with the applicable state and federal laws.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality.
4. The report for this assessment will be sent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client’s responsible party. I agree to help as much as I can, by supplying full answers and working as best I can to make sure that the findings are accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian Date Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name Date of Birth

I, the psychologist, have discussed the issues 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of psychologist Date

❑ Copy accepted by client ❑ Copy kept by psychologist

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*