Informed Consent for Psychological Testing

Savana Howe Psy.D.

Please read the entire document carefully, and any questions for clarification. There will be no modifications to any statement or policy in this document, except when provided in writing and signed by Savana Howe, Psy.D., and the party to which the modification applies.
The following document contains information regarding the provision of psychological testing services provided by Savana Howe, Psy.D

Confidentiality

You are entitled to privacy in regards to the pursuit of psychological testing services for yourself and/or your children. This means your clinician cannot share, without your express written permission, that you are working with me. There are, however, some exceptions to this. Limits to confidentiality include the following items:

1. I am required by law to report to the authorities the following circumstances: Suspected past, current, or the possibility of future child abuse/neglect. Suspected past, current, or the possibility of future viewing of child pornography. Suspected past, current, or the possibility of future elder/dependent adult abuse/neglect. If the client is a danger to himself/herself or if I have knowledge that the client is a danger to someone else. In the event that a report has to be made, I will make all efforts to include the client/parent/legal guardian in this process; however, understand that this is not always possible. I am committed to working through whatever issues that may arise as a result of a legally mandated report.

2. I will utilize a collection service for unpaid balances on services rendered. All efforts will be made to resolve the issue without resorting to this, but if you are unresponsive to these efforts then I will initiate collection services. If this occurs, understand that certain personal information will need to be disclosed to this agency. I will only disclose the minimum amount necessary to collect payment.

3. I can also ultimately be ordered by a judge to disclose clinical material. I will make efforts beforehand to try and reach a compromise if needed, but ultimately, if ordered by a judge, I must disclose the requested material. In extreme circumstances this can include the entire clinical record.

4. Although I am permitted to utilize phone, text and email communication, I need to make you aware that this communication can be intercepted, and therefore I cannot guarantee confidentiality.

Therefore, you agree that phone, text, and email communication should be limited to only scheduling and billing matters, and whenever possible clinical matters should be discussed in-person or via secure HIPPA-compliant video platform.

5. At times, it may be beneficial for me to collaborate with other individuals you/your child are working with, e.g. psychiatrists, physicians, and/or other collateral service providers. If it appears that collateral service provider information would inform your child's treatment, I will obtain a signed release from you so that I may collaborate with this/these individual(s).

6. In the treatment of children in particular, it is very helpful for me to collaborate with teachers, speech therapists, occupational therapists, etc. in order to best serve your family. I will consult with you regarding any releases that seem appropriate, as well as discuss the nature and scope of any information shared.

7. In order for me to prepare the most comprehensive psychological evaluation, you may be asked to provide any prior testing and/or evaluation results or reports. Any relevant information received from prior service providers may be included in the current report.

Confidentiality in the Treatment of Children and Adolescents

In the treatment of children and adolescents, the parent(s) or legal guardian is legally entitled to all information shared and obtained through the provision of services. However, it is clinically contraindicated for a child or adolescent to not have confidentiality in the treatment process.

Please understand that I am committed to working with your child/teen to make healthy and adaptive decisions for himself/herself. However, issues that I will not share with you include: drug and/or alcohol use, tobacco use, sexual behavior, sexual identity concerns, time spent in activities that he/she does not have parental permission for, e.g. spending time with friends, involvement with gangs, fighting, ditching, truancy and other school-related behavior, and/or other delinquent behavior.

Please note that if any of these concerns rise to danger to self or others, I will make the appropriate disclosures and reports. The reason this policy is so stringent pertains particularly to the treatment of adolescents. If they are concerned that I will tell you details of their personal lives, they will likely not disclose, and we will miss critical opportunities to work with them to make better, healthier decisions. I will share with you the general themes and issues we are addressing in treatment.

This confidentiality policy is not intended to restrict our communication with one another. You are free to contact me at any point during your child's treatment to discuss progress and any other related concerns. I am committed to having a strong working relationship with the entire family.

There may be times, specifically related to psychological testing, when sensitive information will be disclosed as part of the report. This includes the examples written above. I will only include this type of information if it is clinically relevant to the testing referral question. Additionally, I will speak with your child/adolescent about the possibility that certain disclosures may need to be included in their final report.

Treatment of Children of Separated or Divorced Parents

In the treatment of children whose parents are separated or divorced, a number of issues can arise. By signing this document, you confirm that you understand and are in agreement with the following policies:

Each parent will be given equal time with the clinician regardless of which parent initially contacts me. Furthermore, both parents will be given an opportunity to participate in the parent check-in portion of treatment when clinically appropriate. A signed release of information will need to be obtained from the custodial parent in order to share information with the non-custodial parent.

Exceptions to these policies include but are not limited to: when a parent lives out of state, is incarcerated, has a restraining order in place against him/her, has no contact with the child(ren)/family, and/or does not have legal authority to make decisions regarding the mental health treatment of their child (as specified in court documentation). I am available to consult by phone with parents who live out of state, and these sessions will be billed at the agreed upon fee.

I will not make recommendations regarding visitation or custody. I do not conduct forensic evaluations, therefore I will not communicate with attorneys for either parent about visitation or custody. Exceptions include when required by law (e.g. court order or subpoena).

Please provide me with a copy of the section within your divorce decree and/or court order that specifies legal custody agreement.

Ideally, both parents should consent to treatment. Rare exceptions are clinically determined case by case or mandated by court documentation. Information provided by one parent may be shared with the other in order to facilitate treatment, as clinically warranted.

Psychological Testing

Psychological testing can be used alongside behavioral health treatment to help identify, quantify, measure, or clarify psychological symptoms or behaviors. Psychological testing that is used as adjunct to another service (e.g. psychotherapy) will not be formally written up in a Psychological Evaluation. However, the assessment will be fully explained to the client and their parent(s)/legal guardian(s) prior to the administration, and results will be discussed with both.

Psychological Evaluations

A Psychological Evaluation is a process wherein a series of psychological tests are administered in order to identify and understand a client's cognitive, social, emotional, developmental, and personality strengths and weaknesses. Once these strengths and weaknesses are identified, a comprehensive report is written, typically culminating with a diagnosis (or diagnoses) and treatment recommendations.

Final Report

You will be given a copy of the final report during the feedback session. This report will be comprehensive and include potentially sensitive information. Once you have your report, it will be your decision to share it with others. This includes schools, physicians, and any other service providers. Please note that I will not provide redacted and/or abbreviated reports.

However, if the family wants a summary of test scores without background information, that is available for a nominal fee of $50. Please note: that the summary of test scores will clearly state the presence of a report with background information, because of the professional ethics around psychological testing. Concerns about this should be discussed with me at the feedback session.

Furthermore, I reserve the right to refuse to redact the report and only provide a summary of test scores.

Scheduling and Length of Treatment

Psychological Evaluations are typically completed between 30-60 days from the first appointment. In order to expedite services, I require that the families schedule the intake, all testing appointments, and feedback at the same time. If testing does not start within 30 days of an intake appointment, a new intake appointment will have to occur.

Children and adolescents test best in the morning hours, and will need to be tested within a short time frame of 2-3 weeks. Results of the psychological evaluation will be thoroughly explained in a mandatory in person feedback session, where I will review the results of all testing, explain the diagnostic impressions, and discuss treatment recommendations.

Treatment Concerns

I am committed to working with you and your family. Please speak with your clinician and me about any concerns regarding treatment at any time.

Your signature below denotes that you have read all of the information provided above, understand it, are in agreement with it, and consent to proceed with treatment. Your signature also indicates that you have been provided with the opportunity to ask questions. This authorization remains in effect until services are terminated.

Client Name_____

(Print)

Parent/Legal Guardian Name_____

(Print)

Parent/Legal Guardian_____

(Signature)

Date_____