GEORGETOWN
PSYCHOLOGY ASSOCIATES

INFORMED CONSENT FOR EVALUATION SERVICES

Welcome to Georgetown Psychology Associates. This document contains important information about our professional services, business policies, and privacy rights. Please read it carefully. We will be happy to answer any questions you might have. When you sign the last page of this document, it will represent an agreement between us.

PROFESSIONAL SERVICES

Our evaluation team consists of the following licensed psychologists: Dr. Maria Zimmitti, Dr. Elizabeth Malcolm, Dr. Jillian Egan, Dr. Mollie Dee, Dr. Caroline Spearman, Dr. Jill McCulloch, Dr. Leslie Klein, and Dr. Jessica Pavlick. Please consult our website (www.georgetown-psychology.com) for biographies, information about our services, and helpful resources.

BUSINESS POLICIES / PAYMENTS

Georgetown Psychology Associates values your time and we appreciate you valuing ours. We have a waiting list for testing appointments; therefore, all cancelled appointments are subject to a charge. If you cancel your appointment with at least 3 weeks prior to the first testing appointment, a cancellation fee of $250 as well as time spent on the case at a rate of $300/hour will apply (e.g., parent intake, teacher interviews, etc.). Cancellations less than 3 weeks prior to the first testing appointment will incur a $500 fee as well as time worked on the case at a rate of $300/hour.

Payment is due at the time the evaluation is scheduled. We accept Visa, MasterCard, Discover, and American Express.

We are not participating providers in any health plans and do not submit insurance claim forms. However, once we have completed the evaluation, we will provide an itemized receipt for you to submit to insurance (when requested). You should check with your insurance or health plan administrator before scheduling the appointment to determine what, if any, services are covered when provided through an "out-of-network" professional. If you are a parent seeking testing for your child, please be aware that you have the right to request testing at no charge through your child's local public school, although the school team may or may not make this recommendation.

In rare cases in which the evaluation fee has not been paid prior to evaluation appointment, please know that analysis of tests does not start until all fees are paid. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, legal measures (an attorney or collection agency) will be taken. In most collections situations, the only information released is a client's name and contact information, the nature of the service provided, and the amount due. All accounts past due will be subject to late fees, 1.5% interest, and all costs of collections.

CONFIDENTIALITY AND PRIVACY POLICY

In general, law protects the privacy of all communications between a client and a psychologist, and we must have your written permission to release information about the evaluation. There are a few exceptions. If we have

reason to suspect that a minor is being abused, we are legally obligated to file a report with the appropriate state or federal agency. We are also required to take protective action if we believe a client is threatening serious bodily harm to self or others. In some cases, a judge can order us to release confidential information.
All test reports go through a detailed review process that may include Dr. Zimmitti, other staff psychologists, and/or Dr. Nancy Heiser and Dr. Jody Bleiberg who are consultants to our practice.

Please be assured that, with these few exceptions, all services provided are confidential. We will discuss evaluation findings and/or talk with other professionals or individuals only if you have signed a Release of Information form. You have the right to rescind your consent at any time.

If you have any questions about the information contained in this form, please contact us to discuss. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Please upload this form prior to the intake appointment.

ADDITIONAL NOTES
Prescription medication should be taken as usual. Please discuss with the evaluator if you have any questions.

Reports will not be released prior to the feedback session. We believe that the information gained from the testing process is best communicated in person with the evaluator.

Name of Client / Child: _____

_____ _____

Signature (Adult Client or Parent 1) **Date**

_____ _____

Signature (Parent 2)* **Date**

***Note:** If you are currently separated or have a joint custody agreement in place, both parents must sign this form. Both signatures are also required when one parent has legal/medical decision making authority. Testing cannot be conducted without the expressed consent of both parents. If you have a sole custody agreement in place, please submit documentation with your paperwork prior to the intake appointment.

ADULT BACKGROUND INFORMATION

At Georgetown Psychology Associates, we strive to create a non-judgmental, open, and safe atmosphere, where equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.

DEMOGRAPHICS	
Legal Name Preferred Name & Pronoun	
Today's Date	
Date of Birth / Age	
Address	
Phone and Email	
Race / Ethnicity / Gender	
Relationship Status	
Age / Names of Children	
Household Members	
Primary Language and other languages	
Spiritual/religious affiliation (if any)	
Current Employment and Brief Employment History	

Educational History (Dates, Schools, Degrees) Please note grades repeated.	
Birthplace and places lived.	
Emergency Contact (Name, relationship, phone/email)	
How did you hear about us?	

MEDICAL & PSYCHIATRIC HISTORY
Describe any serious illnesses, surgeries, hospitalizations or head injuries. Describe any allergies, chronic ear infections, and medical conditions. List all medications you are currently taking (and prior psychiatric medications with dates). When were your vision and hearing last checked and what were the results? Describe family medical history (e.g., ADHD, anxiety, depression, substance abuse, cancer, diabetes). Please describe any social or emotional problems and treatment received. Have you ever been hospitalized for a psychiatric problem or attempted suicide? If so, please describe.

Has anyone in your immediate or extended family committed suicide? If so, please describe.

Do you have any history of harming others or legal problems? If so, please describe.

BIRTH AND DEVELOPMENTAL MILESTONES

Were you adopted? ___ No ___ Yes, at age ____

Were you born full-term or premature (if premature, note gestational age)? Describe problems during delivery, infancy and development (e.g., delays in talking, walking?) and exposure to substances in utero.

PRESENTING PROBLEM AND HISTORY

Describe your concerns and specific questions you would like addressed.

When were these problems first identified?
Describe how the problems have manifested in your personal life and at school and work.
Please describe prior/current psychotherapy and medication treatment and if it was helpful.
Have you received psychological or psychoeducational testing in the past? If so, please list evaluations and key findings and attach copies if available.

Have you received interventions in the past or currently such as therapy, tutoring, medication, special education/IEP services, speech therapy, and occupational therapy? If so, list services and dates or time periods received. Please indicate if services were provided through the school or through private sources.

Reasons for Seeking Therapy or Testing
Please check items that apply to you.

☐ Depression	☐ Attention problems
☐ Anxiety / worry	☐ Memory problems
☐ Substance abuse	☐ Impulsivity
☐ Relationship problems	☐ Learning problems
☐ Eating / weight issues	☐ Sleep problems
☐ Sexual problems	☐ Chronic pain
☐ Gender identify concerns	☐ Academic problems
☐ Trauma	☐ Occupational problems
☐ Grief	☐ Financial Problems
☐ Anger	☐ Family issues

Other:

Please describe any other information you would like to share to help with your treatment:

I certify that the above information is accurate. I understand this information will be included in my Clinical Record and will be used and disclosed only as described in the Consent Form.

_____ _____ _____

Printed Name Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Georgetown Psychology Associates to seek and share the following information regarding myself, (name)_____,(Date of Birth)_____ for the purpose of:

Person(s) with whom Georgetown Psychology Associates may exchange information:

Name	Address	Phone Number

INFORMATION TO BE SHARED

____History/Treatment/Opinion ____Previous/Current evaluations and reports

I understand that this authorization is valid for one year from date of signing and can be revoked at any time by providing written notice of such revocation to Georgetown Psychology Associates.

_____ _____

Signature Date

_____

Print Name