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.

CHILD & ADOLESCENT 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.

FORM				
Today's Date				
Person completing this form				
Who referred you to our office?				
FAMILY HISTORY				
Child's Name			Gender	
Date of birth			Age	
Current School			Grade	
Parent Name (1)			Occupation	
Address				
Phone number	Home:	Work:	Cell:	
Email address				
Parent Name (2)			Occupation	
Address				
Phone number	Home:	Work:	Cell:	
Email address				
Marital status of parents				
If parents are separated or divorced, which parent has sole legal custody or is legal custody joint?				
Please list name(s) of Stepparent(s)				

List names of all people living in household (relationship to child & age)	
List any siblings living outside the home (names and ages)	
Primary language spoken in the home	
Other languages spoken	
Briefly describe your concerns about your child and specific questions you would like answered by the testing?	
Has your child ever been evaluated? Please list all previous meetings with psychologists, psychiatrists, neurologists, speech pathologists, occupational therapists. If evaluations were done, please attach copies	
List all blood relatives who have any learning, medical, and/or emotional issues, including diagnoses of depression, anxiety, OCD, ADHD, etc.	
Describe any current marital and/or family stress	

SCHOOL HISTORY			
Please list all schools attended, including preschool			
School	City, State	Grades Attended	
List grades and learning / behavioral problems noted			
Do you see these behaviors at home?			
Has your child ever received special education services (tutoring, speech, OT). If so, list services and dates/grades received. If the service was provided privately, rather than through the school, please note			
BIRTH AND DEVELOPMENTAL HISTORY			
Was your child adopted?		If so, at what age?	
Was your child born full term or premature (if premature, note gestational age)?			
Describe any complications with the pregnancy or birth (cord around neck, difficulty breathing, etc.)			
Birth Weight		Apgar scores, if known	

Describe your child's infancy period, including temperament, difficulties with sleep, feeding, irritability	

Provide ages your child achieved the following developmental milestones

Sitting		Crawling	
Walking		Babbling	
First words		Complete sentences	

MEDICAL HISTORY

Describe any serious illnesses, surgeries, hospitalizations or head injuries

Describe any allergies or chronic ear infections

List your child's medication history (note current medications)

When was your child's last vision and hearing checks and what were the results?

SOCIAL-EMOTIONAL

Describe your child's temperament

What do you enjoy most about your child

List your child's favorite activities

Describe your child's ability to get along with peers and adults, including authority figures

Please check all behaviors that currently describe your child; if the behavior occurred in the past and is no longer present, write a "P" on the appropriate line:

Vestibular (Movement and Balance)

☐___Becomes overly excited after movement activity
☐___Thrill seeker on playground
☐___Avoids movement equipment on playground, prefers to play on: _____
☐___Seeks intense movement: spins, twirls, bounces, jumps, rocks
☐___Shakes head vigorously, assumes upside down position frequently
☐___Uncomfortable on elevators, escalators, motion sickness
☐___Excessive dizziness or nausea from swinging, spinning, riding in care
☐___Preoccupied with movement activities, can't sit still
☐___Avoids activities which require balance/losses balance easily
☐___As infant, tended to arch back when held or moved
☐___Trips easily, clumsiness
☐___Fear of heights, climbing, fear
☐___of falling when no real danger exists
☐___Hesitant when climbing or descending stairs (seeks hand, railing or walls)

Proprioceptive Functions

☐___Difficulty controlling movement uses to little or too much power/force
☐___Poor posture/postural instability
☐___Slumps in chair with rounded back and head forward and extended
☐___Pops head on hand or forearm
☐___Difficulty changing positions or moving slowly
☐___Craves tumbling or wrestling
☐___Frequently gives or requests firm or prolonged hugs
☐___Plays roughly with people or objects
☐___Bumps into things
☐___Leans on objects, people for stability
☐___Joints extremely flexible

Tactile Function

☐___Excessive reaction to light touch sensation (anxiety, hostility, aggression)
☐___As infant, not calmed by cuddling/stroking
☐___Difficulty standing in line or close to other people
☐___Stands too close to people to the point or irritation
☐___Tenses when patted affectionately
☐___Negative reaction to unseen, unexpected touch
☐___Clothes cover entire body, regardless of weather
☐___Wears minimal clothes, regardless of weather
☐___Avoids certain textures of clothing, materials
☐___Avoids putting hands in messy substances/getting dirty
☐___Engages in self-injurious behavior(s). List: _____
☐___Likes to be wrapped tightly in sheet or blanket, seeks tight spaces
☐___Engages in self-stimulatory behavior(s). List: _____
☐___Frequently adjusts clothing as if feeling uncomfortable
☐___Touches everything, can't keep hands to self
☐___No apparent response to being touched or bumped
☐___Avoids busy, unpredictable environments
☐___Extreme reaction to tickling
☐___Appears under/over sensitive to pain (circle if applicable)
☐___Socks have to be just right: no wrinkles, twisted seems
☐___Picky eater. Prefers certain textures. List: _____
☐___Limits self to particular foods/temperatures. List: _____
☐___Avoids/seeks going barefoot on textured surfaces (grass, sand)

Auditory

☐___Overly sensitive to loud sounds or noises
☐___Covers ears to shut out auditory input
☐___Hears sound others don't hear, or before others notice
☐___Sensitive to certain voice pitches
☐___ "Tunes Out" or ignores sounds nearby
☐___Unable to pay attention when there are other sounds nearby
☐___Irrational fear of noisy applications
☐___Can only work with stereo/TV on
☐___Hums, sings softly, "self-tasks" through a task
☐___Voice volume too soft or too loud
☐___Seeks out toys, other objects which make sound. List: _____
☐___Craves music, other specific sounds
☐___Needs visual cue to respond to verbal commands or requests
☐___Mispronounces words (bisghetti mazagine, etc.)
☐___Doesn't respond when name is called
☐___Appears not to hear what is said
☐___Frequently asks you to repeat what you have said
☐___Slow or delayed responses
☐___Difficulty sequencing the order of events when telling a story/describing an event
☐___Word finding difficulty
☐___Not precise in word selection

☐___Enjoys strange noises, makes repetitive sounds

Oculo-Motor Control & Visual Perception

☐___Poor depth perception, difficulty or hesitancy climbing or descending stairs
☐___Poor awareness of space in relation to things around self/gets lost easily
☐___Skips words/lines or loses place when reading
☐___Letter/number/word reversals
☐___Overly sensitive to lights/sunlight
☐___Poor eye contact
☐___Hypervigilant or visually distracted
☐___Writing illegible/misplaced on lines or page
☐___Dislikes/likes drawing
☐___Over stimulated by busy visual environment
☐___Keeps eyes too close to work
☐___Tilts head/props head/lays head on arm with desk work

Taste and Smell

☐___Highly sensitive to common odors or to faint odors unnoticed by other
☐___Does not seem to notice unpleasant smells
☐___Tends to overly focus on the taste or smell of non-food items
☐___Will not taste food prior to smelling it and approving of its smell
☐___Prefers bland foods/highly seasoned foods (Circle appropriate one)
☐___Hypersensitive to body odors suck as breath or scents of soap, perfume etc.

Fine Motor Skills

☐___Difficulty drawing, coloring, cutting
☐___Lines drawing are too light, wobbly, too dark, breaks pencil often (Circle appropriate)
☐___Poor hand writing in printing, cursive
☐___Lack of well-established hand dominance
☐___Difficulty using two hands together
☐___Prefers to eat with fingers
☐___Snaps/zippers/buttons are difficult/impossible to manage
☐___Immature grasp of tools such as pencil, fork, spoon, toothbrush
☐___Enjoys manipulative, puzzles, construction toys, coloring, drawing (Circle appropriate)

Self-Regulation

☐___Oversensitive, undersensitive, fluctuating sensitivity to stimuli
☐___Unusually high, low, fluctuating activity level
☐___Difficulty with transitions or change
☐___Difficulty modulating behavioral state

Emotional/Social Behavior
☐___Intense, explosive ☐___Easily frustrated, anxious ☐___Can't sit still, hyperactive ☐___Clingy, whiny, cries easily ☐___Stubborn, inflexible, uncooperative ☐___Poor self-concept/ low self-esteem ☐___Highly sensitive/can't take criticism ☐___Gives up easily ☐___Hard to awaken ☐___Hard to get to sleep ☐___Tantrums ☐___Fearful (list): ☐___Unable to adjust to changes in routine ☐___Slow to, or unable to make timely transitions ☐___Prefers company of adults to older children ☐___Prefers to play with younger children ☐___Easily discouraged or depressed ☐___Enjoys team sports ☐___Poor loser

(sensory profile adapted from Zier & Carrick)

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

_____ _____ _____

Parent Name Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Georgetown Psychology Associates to seek and share the following information regarding my child, (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.

_____ _____

Parent 1* Signature and Date Print Name

_____

Parent 1* Address Phone Number

_____ _____

Parent 2* Signature and Date Print Name

_____

Parent 2* Address Phone Number

(***signature of both parents required unless adult or documentation of sole custody or court ordered guardianship is attached to consent form**)