ORION
BEHAVIORAL HEALTH NETWORK

Patient Name:

_____

DOB:_____

Consent for Psychological Assessment/Testing of a Child or Adolescent

Welcome to Orion Behavioral Health Network's Psychological and Neuropsychological Assessment Services. This document contains important information about the professional services and business policies. Please take a moment to read it carefully and ask the staff to clarify anything that does not make sense to you. When you sign this document, it will represent an agreement between OBHN and the patient/parent/guardian.

I, _____, agree to allow the OBHN Assessment Psychologist to perform the following services:

X Psychological diagnostic testing, assessment, or evaluation

X Report writing

__ Other (describe)

I understand that these services may include direct, clinical interviewing, administration of psychological services, and feedback/review of results appointments. There will also be charges for the psychologist's time required for the reading of records, consultations with other health professionals, scoring, interpreting results, report writing, and any other activities to support these services. Areas to be assessed may include (but not limited to) cognitive and academic functioning, attention and concentration measures, psychological functioning, adaptive functioning, etc. Psychological assessment and testing are voluntary and patients may withdraw from participating in the process at any time. However, this may affect the results. I understand the psychologist will be selecting tests that are suitable to the referral question from the provider.

I understand that the fees for these services may be covered by my insurance. Although health insurance may repay me for some of these fees, I understand that there may be co-pays and additional fees not covered by my insurance. I understand that I am fully responsible for the payment for any services not covered by my insurance or services provided when we do not participate as a provider under your insurance plan. I understand that insurance companies may have access to reports from services provided by OBHN. I authorize the exchange of information necessary for payment of services.

I understand that psychological assessment services may have some limitations and so predictions of its benefits, outcomes, or durations are not precise or guaranteed. The results and recommendations from the psychological assessment are data driven and may or may not reflect the beliefs and desires of the patient or their family.

No-Show Policy

I understand that an appointment is a commitment. If I miss an appointment or do not cancel at least 48 hours in advance, I will be charged for the appointment. I understand that I will be subjected to a **$250.00** missed appointment fee for a testing block. I understand I will be subject to a $50.00 for any missed one-hour block (i.e., clinical interview or feedback). If the initial interview appointment is missed, the testing session will be rescheduled, which typically results in a considerable delay. Please note insurance will not cover "No Show" fees, and must be paid in full prior to rescheduling any missed appointments.

Confidentiality

All test data will be kept confidential and in a safe place. Information and results obtained will not be released without parent(s) or legal guardian's consent. For additional information please see the informed consent section: Records Released.

Although you or your child has the right to confidentiality from most people while seeing a psychologist, there are some standard exceptions to confidentially as described below.

All patients are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever

information about you/your child is transmitted electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. Please see our Notice of Privacy Practices.

Exceptions to confidentiality

- I understand that if the psychologist believes that the patient is imminent danger of harm to themselves or others; the psychological examiner may legally break confidentiality and call the police, EMS, or the nearest crisis intervention team in order to ensure the patient's safety.

- I understand that if the psychologist learns of abuse/harm to children or vulnerable adults, the psychological examiner is required by law to report this suspected abuse to the Office of Children's Services (OCS) and/or Adult Protective Services (APS) immediately.

- I understand if I or my child is ever involved in any legal proceeding and the psychologist is court ordered by a judge to disclose information about and/or supply documentation about the patient of record then the psychological examiner must comply with all lawful orders of the courts.

Research

From time-to-time OBHN conducts research into our practices and specifically the use of tele-health to deliver services. We would request your consent to use aggregated patient data in any future research projects we may conduct. All patient's protected health information would continue to remain confidential, only averages of age or numerical data would be included in any research papers. Your consent is completely voluntary and if at any time you wish to revoke your consent for research you may do so without it impacting you or your child's care at OBHN in anyway. If you have any questions about this section please ask the assessment psychologist.

Amendment Policy

It is OBHN's policy that psychological assessment reports are generally not amended if the requested change does not directly affect the diagnosis and/or treatment recommendations. All requests for additions and/or changes must be placed in writing within 14 calendar days of the report being finalized. The director of assessment will review the written request and if appropriate include the document into the patient's medical record and that document will be included as an attachment to the report. Any changes to psychological data, clinical summary, and recommendations will never be made per parent, patient, or third party request. I acknowledge this policy and understand that any request to amend my final psychological evaluation will be denied if the requested information to be changed does not directly affect the diagnosis or treatment recommendations.

Consent to Assessment

I have read, or have had read to me this agreement; I have had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it fully. I understand the limits to confidentiality as required by law. My signature indicates my voluntary consent for the psychological assessment.

Signature of Patient/Parent/Guardian	Printed Name	Date

Signature of Parent/Legal Guardian	Printed Name	Date