Hope Springs Counseling Center, LLC
127 ½ North Broad Street, Suite 3, Monroe, GA 30655
(404)784-6809

INFORMED CONSENT FOR COMPREHENSIVE TESTING OF ADOLESCENTS AND/OR ADULTS

Purpose of the Evaluation

Sherie Malcom, Ph.D., LPC, NCC will conduct an evaluation to examine psychological functioning. The purpose of this evaluation is to determine if there is a potential psychological problem or condition. This will include your background and family history, psychological adjustment, and personal history.

T***ests Used***

You will be administered a battery of psychological tests as part of the evaluation process. Those tests will include some or all of the following:

Interview: You will be interviewed regarding your psychological history and family history as related to your current problem. Additional information will be gathered from your parents, records, and other sources as needed. Your parent or caretaker will be interviewed if they are available.

Uses of the Testing

The overall purpose of the testing is to help identify your potential psychological problems, if any. The test data is used in the following ways:

To help develop an understanding about your psychological problems and personality traits.

The fee for this evaluation is $995. This covers up to 10 hours of work. If additional hours are needed, the evaluator will discuss this with you. The appropriate fee must be paid before service is rendered.

Consent

I understand that additional testing, expert testimony in court, conferences with attorneys or court officials, and telephone consultations about the report will be charged at $200.00 per hour. If I plan to call my therapist/evaluator as an expert witness in my case, then I agree to pay a

$1000.00 retainer fee in advance which will cover 5 hours of service. I understand that I will be billed for any hours that exceed the 5 hours covered by the retainer fee. If the amount of time does not exceed 5 hours, I will be reimbursed for the difference.

I understand that by signing this Informed Consent Form, I agree to all terms and conditions contained herein and hold harmless Sherie Malcom and Hope Springs Counseling Center.

I also understand that no test results will be released from this clinic without my express written consent. If you would like for the test results to be released, please fill in and sign the Release of Information form attached.

My signature below indicates that I have read and understand the above-stated conditions of testing, payment, and information release.

Signature of Client: _____ Date: _____

As the legal guardian, I give permission for this evaluation to be conducted, and I accept responsibility for all fees incurred. I have read the above information and agree to all terms and conditions contained herein and hold harmless Sherie Malcom and Hope Springs Counseling Center.

Signature of Legal Guardian: _____ Date: _____