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CONSENT for Psychological Testing and Evaluation

Tax ID: 46-22813454
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Client Name: _____

DOB: _____

The assessment procedures used are based upon the individual's needs and will include a combination of the following major categories:

Developmental: Thorough developmental history including perinatal issues, milestones, signs and symptoms suggestive of pervasive developmental disorders (e.g., ASD), sensory processing, and temperament.

Cognitive: Assess pattern of cognitive abilities across multiple domains including, verbal skills, abstract thought, visual-spatial ability, problem solving, and social comprehension. Academic skills and achievement are assessed in the areas of reading writing and mathematics including screening for specific learning disorders. The evaluation also assesses for executive functions and/or symptoms of ADD/ADHD including attention, impulsivity, working memory, and processing speed.

Emotional: Assess emotional functioning including emotional regulation, mood, depression, anxiety, obsessive-compulsive disorders, sleep problems etc.. Assess personality functioning and identity development.

Behavioral: Screen for a wide range of behavioral issues including but not limited to substance abuse, trauma and abuse, self harm, aggression, and other high risk behaviors.

CONSENT to Administer Psychological Testing and Communicate with Other Providers

I hereby agree to psychological testing for the child/adolescent named below. I understand that all original test protocols and materials generated from the assessment are the property of Dr. Zeisz. I understand that I (parent or guardian) will be in possession of the finalized written report to share as is appropriate with other professionals involved with my child/adolescent. I understand that the results of the assessment may be used by my child/adolescent's current program/provider as well as to make recommendations for future program placement, treatment, and/or educational setting. This consent **DOES INCLUDE** the ability for Dr. Zeisz to share/exchange verbal and written information as part of the evaluation process with your child/adolescent's therapeutic program or treatment facility if applicable. This consent also includes the ability to share/exchange information with your educational consultant if applicable.

Name of Parent/guardian: _____

Signature of parent/guardian: _____ Date: _____