SPECTRUM
PSYCHOLOGICAL SERVICES
Solving Puzzles One Child at a Time.

Consent for Services

I, _____, having legal responsibility for the minor child, _____, am aware of the need for services of the above named minor child. These services will be provided by Sarah S. Golsen, Psy.D. and may include: (a) psychological testing which may include the administration of academic/intellectual/social-emotional/behavioral/neuropsychological assessment tools, and/or (b) individual and/or family therapy services, and/or (c) parent training, and/or (d) consultative services. I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. If I have any concerns about these services, the psychologist is available to discuss my concerns.

I understand that I am financially responsible for the fees for service. I understand that there will be a $35.00 service charge on returned checks. In the event that I am unable to pay for services, I also understand that a collections agency could be used for severe delinquency.

I understand there is a 24-hour cancellation policy, which requires cancelling the appointment 24 hours in advance to avoid being charged. Leaving a message by voicemail on nights and weekends is acceptable. The full fee for services will be charged if appropriate cancellation is not made.

I am also aware that my child's records and services will be treated in accordance with the policies of confidentiality of the American Psychological Association's Code of Ethics. Circumstances which warrant breaking confidentiality may include: (a) if my child is in danger of causing life-threatening self-injury, (b) in cases where there is information suggesting past or current child abuse, (c) if others are in danger through the actions of my child, (d) if ordered by the Courts to turn over case information, or (e) in cases of medical emergency. State law requires that suspected child abuse or neglect be reported.

In order to insure the highest standard of care, Dr. Golsen also reserves the right to consult with other professional staff regarding the treatment of my minor child. This consultation will be held in strict confidence, also in accordance with the policy of confidentiality of the American Psychological Association's Code of Ethics.

(check one)

___ I GIVE MY PERMISSION for services from Sarah S. Golsen, Psy.D.

___ I DENY MY PERMISSION for services from Sarah S. Golsen, Psy.D.

_____ _____

Parent/Legal Guardian Signature Date Witness Signature Date

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