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Informed Consent for Minors

Please read this document carefully so that you can make an informed decision about your child participating in a psychological evaluation. This information will help you understand better what to expect, and it will explain some limitations about what your child and the tester will be doing.

Your Privacy and Confidentiality

During the course of the evaluation, our conversations, your records, and any information that you or your child give us is protected by something called legal privilege. That means that in most cases the law protects you from having information about you given to anyone without your knowledge and permission. Our office respects your family's privacy, and we intend to honor your privilege. However, the law also makes some important exceptions to your privacy.

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent/guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and the police.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused—physically, sexually or emotionally—or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third-party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature, below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary for them to pay for your services. If we find ourselves in a dispute with you over

billing, our office may provide a collection service any information necessary to clarify and to collect an outstanding balance.

The Testing Process

Generally, the psychological evaluation will involve three sessions—a collateral interview with parents/legal guardians, testing the child, and feedback. Testing sessions can be long and even extend across multiple days. The psychological evaluation may include: a review of previous records; direct, face-to-face contact; clinical interviews; additional information from your school/employer (with written permission); as well as formal testing. These services will also include the psychologist's time for the reading of records, interpretation of the test results, writing of the report, and any other activities to support these services. Scoring, analyzing, and writing a report based on testing typically takes a few weeks, at which point the parents will be contacted for their third session. Feedback may involve only the parents/legal guardians or also include the child based on the patient and results.

Our office specializes in comprehensive psychological evaluations that include a wide range of areas, including cognitive abilities, academic achievement, personality assessment, and emotional functioning, depending on the questions to be addressed. If we believe that your child's condition requires knowledge that we do not have, we may refer you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act.

During the evaluation, you may be invited to participate in research studies. Your decision of whether or not to participate will not affect your treatment here or your relations with Dr. Gould in any way. However, by signing this form, you are agreeing to allow use of the data from your assessment for research purposes (i.e., papers, conference presentations, etc.), provided that all identifying information is removed.

Telemental Health

In light of the social distancing measures in place due to COVID-19, Telemental Health sessions are available and encouraged for all appointments. The virtual sessions will take place through a HIPAA compliant platform. In order to take advantage of this service, the family must have access to a camera on a computer or smartphone, an Internet connection, and a secluded and quiet space for the session. All parties involved must agree not to record the session. Additionally, any testing material sent to you may not be copied, reproduced, or published. That being said, by the nature of these virtual visits, your child's confidentiality may be more at-risk than it would in an in-person visit. I may also ask to establish a Safety Plan with the parent prior to the appointment in the case of an emergency. This could include the information of an emergency contact and the hospital nearest you. If I feel that Telemental Health is not in your child's best interest, I reserve the right to suspend virtual visits. Finally, we will verify whether your insurance carrier covers Telemental Health and let you know prior to the session. If your insurance carrier does not cover virtual visits, you may choose to pay for them privately.

Child Custody and Parental Rights

In order to authorize mental health services for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize services for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health services.

One risk of providing psychological services to children involves disagreement among parents and/or disagreement between parents and the psychologist regarding the child's services. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's evaluation to progress. Ultimately, parents decide whether psychological services will be conducted. If either parent decides that the psychological evaluation should be terminated, I will honor that decision, unless there are extraordinary circumstances.

By your signature(s) below you consent to the psychological services offered herein, you agree to pay for services as indicated and at the time of service, and if you are using a third party payer (e.g., insurance), you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment of services. Further, you agree that all charges are, finally, your responsibility, and that in the event your insurance carrier refuses payment, you agree to pay all amounts due.

_____ _____

Signature of Patient* Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date

*Minors are generally not required to sign