Elizabeth L. Anderson, Psy.D.
Licensed Clinical Psychologist
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Lawrenceville, GA 30043 **770.674.8257**

INFORMED CONSENT FOR PSYCHOLOGICAL TESTING

Welcome to Life Transformation Psychological Center, PC! Thank you for choosing me (Dr. Elizabeth L. Anderson, Psy.D.) as your provider for mental/behavioral health services. You have taken a very significant step by deciding to seek treatment, and I view it as an honor to serve you and your mental/behavioral health needs. This form provides you with information about my services, and about your rights and responsibilities as a client. Please be sure to discuss any questions with me. Your signature at the bottom indicates that you understand the information and freely consent to treatment.

Background: I received a Bachelor of Science degree in Marketing from Oklahoma State University, and a Master of Arts degree in Clinical Psychology as well as a Doctor of Psychology (Psy.D.) degree from Regent University. I am a Licensed Clinical Psychologist in the state of Georgia (psychology license number PSY003783). I have several years of experience providing psychotherapy and psychological testing services to child, adolescent, young adult, adult, and geriatric populations. Please feel free to visit my Web sites at www.drelizabethanderson.com and www.lifetransformationpsych.com for more information regarding my educational and clinical practice background.

Confidentiality: Your confidentiality and privacy are very important to me. All mental health records are maintained in accordance with state rules, laws, and ethical guidelines. As a Licensed Clinical Psychologist, there are certain exceptions to confidentiality which include: 1) intent to harm yourself, 2) intent to harm someone else, 3) current situations involving child or elderly abuse, and 4) if a judge court-orders release of records. Personal information about you will never be released without your informed consent by either securing your express written permission or discussing it with you first. If you are involved in litigation and inform the court of the services received in a mental health setting (thereby making your mental health an issue before the court), please be aware that you may be waiving your right to keep your records confidential. Please consult with your attorney before proceeding. Please protect yourself from unnecessary intrusions into your privacy. If your psychological evaluation or treatment is court-ordered, you can assume that all information provided to me will be shared with the court. In those instances, you have the right to tell me what you want disclosed. However, withholding information may be harmful to you. In addition, if you desire that information about you should be communicated to someone else, your written permission will be required. If therapy services include others such as a spouse, written permission will be required from each person before any records will be released.

Fee, Payment, and Cancellation Policy: A minimum of 24 hours is required for cancellations or rescheduling of appointments, as this allows another client to schedule an appointment during that time. As the client, if you do not cancel or reschedule your appointment with at least 24 hours in advanced, you will be charged $50 no show/late cancellation fee (which is not covered by insurance companies). You are responsible for payment at the time of all professional services. It is up to the client to decide whether or not to use insurance coverage for payment of services. Please note that you are also responsible for payment of all services that are also not paid by your insurance company or other parties involved. Fees or co-pays are due at the time of the appointment. Life Transformation Psychological Center, PC & Dr. Elizabeth L. Anderson, Psy.D. will most likely bill the insurance company for you electronically as a courtesy, but ultimately, payment and collection is your (the client's) responsibility. Unless otherwise negotiated or contracted by your insurance carrier, Dr. Elizabeth L.

Anderson, Psy.D. with Life Transformation Psychological Center's fees are as follows: $150 per hour of test administration, scoring, interpretation, and report writing. There may also be other charges for additional time spent on your case. For example, telephone consultations, request for letters or documentation, etc. You will be made aware of such charges before they are incurred. A fee of $150/hour will also be charged for all phone calls, requested documentation, email consultations, or any other services outside of the traditional psychological testing session(s) that requires more than 10 minutes with the client or on the client's behalf. Legal/Court services fees are $200/hour. Note that payment is due prior to additional services or paperwork being completed. There is also a $20.00 returned check fee plus any bank charges. I accept payment for services in the form of cash, checks, Visa, Mastercard, American Express, Discover, and HSA cards. Elizabeth L. Anderson, Psy.D. and Life Transformation Psychological Center, PC reserves the right to use the services of a collection agency to collect outstanding debts.

Electronic Communications: Please be aware that confidentiality via any form of communication utilizing electronic media, such as text messages and email, cannot be guaranteed. If you as the client prefer to communicate via text messaging or email, such as regarding scheduling or cancellations, I will accommodate your preferences, but please reserve all therapy related discussions for our face-to face sessions. This is especially important because important text messages and emails are part of your medical record. Please also be aware that my texts and emails are not encrypted, and that at most, I have a password and virus protection on my computer. That all said, if you prefer to communicate with me via email or text messages, it will be assumed that you have made an informed decision to do so, and that you have agreed to take the risk that such type of communication may be intercepted.

Mental Health Insurance: In order to bill your insurance or EAP Company, I must provide your insurance carrier with a psychiatric diagnosis. In addition, depending on the insurance company, treatment goals, symptoms, progress in treatment, etc. may also be requested by your insurance carrier, or in some rare cases, a copy of your entire mental health record may be requested. Please note that as a psychologist/therapist, I have no control or knowledge over what insurance companies do with the information that is submitted or who specifically has access to your records. Thus, it is good to be aware that by submitting a mental health invoice for reimbursement purposes carries a certain amount of risk to privacy, confidentiality, or to future capacity to obtain health or life insurance. The risk stems from the fact that mental health information is likely also entered into insurance companies' computer systems and is likely also to be reported to the Medical Information Bureau (MIB), a national data bank. MIB is a membership organization of life insurance companies. When life, health, or disability insurance is applied for, the company reports that information to MIB. For example, psychiatric conditions might affect your admission to the military or your future insurability. In order to avoid the aforementioned, private pay for psychotherapy services could be a good option in order to maintain greater control and confidentiality with regards to your mental health records.

If you need to contact me: I can be reached at 770-674-8257, between 9 AM and 5 PM, Monday through Friday. Please note that my private practice is not set up to provide 24-hour emergency care. However, your safety is highly important to me. If you are experiencing a crisis or life-threatening emergency, please call 911 or visit your nearest local emergency room. Furthermore, please contact me in the event of such a situation.

Psychological Testing 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 professions, scoring of tests, interpreting the results, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.

Our Agreement:

I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this brochure, I can talk with you about them, and you will do your best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this psychologist about the results of this assessment.

I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure. I hereby agree to allow Elizabeth Anderson, Psy.D. with Life Transformation Psychological Center, P.C. to conduct this assessment, and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

Relationship to client: ❑ Self ❑ Parent ❑ Legal guardian

❑ Health care custodial parent of a minor (less than 14 years of age)

❑ Other person authorized to act on behalf of the client – specify_____

I, the psychologist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into assessment with the client, as shown by my signature here.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

Credit Card Guarantee of Payment

I understand that Dr. Anderson will be billing my insurance company for therapy or evaluation services, and that I am responsible for all reasonable and customary fees that my insurance company does not pay such as deductibles or co-pays.

Dr. Anderson will work with you and your insurance company to receive payment from them. For your convenience, she will wait a reasonable amount of time to be reimbursed by your insurance carrier for services delivered. However, sometimes insurance companies do not reimburse at the rate that was initially described during the verification of benefits. Due to these possible unforeseen factors, I am giving Dr. Anderson permission to charge my credit card for any services that have not been paid by myself or my insurance carrier within ninety (90) days of billing.

I understand that this form is valid for three years unless I cancel the authorization in writing.

Patient Name

Cardholder Name (if different from the patient)

Cardholder Billing Address

Type of Credit Card

Credit Card Number 3 Digit Security Code

Expiration Date

Signature and Date