INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and consent to psychological services provided by Dr. Wendy Picard. This consent applies to myself, child, or patient named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that psychological services are limited to psychological evaluation, assessment, consultation, and intervention. I understand that evaluation and assessment services may also include the use of psychological tests. I understand that intervention services may include psychotherapy. I also understand that the examiner makes no guarantee of results from psychological tests performed.

I understand and agree that my disclosures and communications are considered privileged and confidential, except to the extent that I authorize a release of information, or under extreme conditions recognized by the American Psychological Association Guidelines, and HIPAA Privacy Rules.

______________________________ ________________

Patient Date

______________________________ ________________

Parent or Guardian Date