Natalie Kollross, PsyD Licensed Clinical Psychologist

Psychological Services of Pendleton, LLC

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CONSENT FOR PSYCHOLOGICAL TESTING AND EVALUATION

I, _____ consent to allow
NATALIE KOLLROSS, PSYD, LICENSED CLINICAL PSYCHOLOGIST

to conduct a Psychological Evaluation of _____myself /_____ my child. (CHECK ONE)

I understand that the purpose of this evaluation is for:

1) _____

2) _____

I understand that this evaluation may include:

1) a face to face interview with **Dr. Kollross** to gather personal history, medical and psychiatric history, and information about my current functioning.
2) psychological testing.
3) collateral contacts with significant others, including family members, physicians, or other treatment providers.
4) a review of written information from previous evaluations, treatment providers, or referring agencies.
5) a written report summarizing results and conclusions.

I also understand that **Dr. Kollross** uses only procedures and tests in accordance with the rules and guidelines of the American Psychological Association, that test scores will be interpreted according to scientific findings and guidelines from the professional literature, and that test questions, answers and results will be kept in a safe place to ensure my privacy and the protection of the integrity of the test instruments. **Dr. Kollross** may have office personnel administer and score certain tests or questionnaires but will be solely responsible for the interpretation of the results herself.

I understand that **Dr. Kollross** may provide me a summary of my results and her conclusions about me from this evaluation either orally or in writing. Unless this evaluation was requested by a third party (see below), I also understand that I may direct her to send a copy of the final written report to those persons I authorize to receive it. I understand this authorization does not include raw test results or test questions which might compromise the integrity of the test or violate copyright law.

By signing below, I agree that I have reviewed and understand the information above.

By _____ Date _____
Patient

By _____ Date _____
Patient's Representative

Description of Representative's Authority _____

CONSENT TO THIRD PARTY EVALUATION

I understand that this evaluation has been requested by a third party:

_____

I understand and agree that the written results of this evaluation will be the sole property of this third party. Because these results will go to a third party, I realize there is no doctor-patient or therapist-client privilege between myself and **Dr. Kollross**, and that information I provide her or that is provided to her by others may be included in her final report to the third party. If I wish to have a copy of the evaluation report, I shall request it from the third party named above.

I understand that I may withdraw my consent to this evaluation and to the transfer of information at any time by means of a written letter. However I also understand that my withdrawal will not be retroactive (that is will not apply to testing information transfer that has already taken place). If I do not withdraw my consent, it will automatically expire within 180 days from the date signed.

By _____ Date _____
Patient

By _____ Date _____
Patient's Representative