

# InSight Psychology and Behavioral Health Services LLC

## Informed Consent for Psychological Testing

For minor subject: Under 18 years of age- Form to be signed by legal guardian, parent or conservator.

### Adult:

I, agree to undergo psychological testing administered by InSight Psychology and Behavioral Health Services LLC (from hereon, referred to as InSight PBHS) and I understand that InSight PBHS has assigned Ronnette P. Ballard, PsyD. a licensed clinical psychologist to conduct the testing and to write the testing report.

### Minor:

I, as legal guardian, parent, or conservator with the understanding that I have the legal authority to grant consent for such psychological testing service on behalf of my child/the child in my legal custody (from hereon, referred to as "testing subject"), agree to have him/her undergo psychological testing administered by InSight PBHS. I understand that InSight PBHS has assigned Ronnette P. Ballard, PsyD., a licensed clinical psychologist to conduct the testing and to write the testing report.

~~~~~  
**I have read, understood and agreed to the following statement as the conditions under which I have given this consent. I also understand that with written notice, I can revoke this consent at any time.**

I understand that the testing process involves the completion of a variety of psychological assessment instruments and personal interviews. The total time of the evaluation may vary and will depend upon the questions I or the testing subject or the referral source who made the testing referral might have. I understand that I or the testing subject may experience emotional distress because of the personal nature of some of the information solicited by the testing process. I or the testing subject may interrupt or discontinue this testing process at any time.

After the testing process is completed, a report based on the results of the testing and information provided by me or the testing subject and others will be written. Unless I indicate otherwise in writing to the psychologist or psychology trainee who administered the testing, this report can be given to the person or agency who referred me or the testing subject for this service and a copy of this report will be kept in the testing subject's treatment record at InSight PBHS. By request and at the expense of the client an appointment with the person who did the testing will be scheduled to discuss the results of the psychological testing.

### Limits of Confidentiality:

Like all treatment records, reports and results of psychological testing are confidential and can be released only with a written consent authorizing such release. However, I understand if I or the testing subject discloses information related to suspected threats of physical harm of self or others, occurrence of child, elder, or dependent adult abuse, or if commanded by court order, InSight PBHS will be required to disclose such information to appropriate authorities or parties mandated by law.

Print Client Name and Date of Birth:

**Signature (If not electronically signed)** \_\_\_\_\_