SIGNATURE FORM

Client: _____ **Office of Dr. Susan Hill**

PERMISSION FOR TESTING

I hereby give permission for an individual study to be made of my abilities and learning potential. I understand that this study may involve examination of records and reports (provided by me or sent at my request), gathering of developmental, educational, and social information, and individual testing. I understand that an individual conference will be subsequently held in which the findings and recommendations of this evaluation will be discussed. Further, I understand that a written report will be provided to me.

It is understood that all information will be handled in confidence, its release being limited to authorized personnel and to those for whom I have authorized its release by signing this Release of Information form, unless required by law in certain circumstances outlined in the Privacy Procedures.

The duration of authorization for each of the areas indicated is in effect for one year from the dated form. I understand, however, that I may revoke my consent through written request at any time.

SIGNATURE(S): Do you agree to the above? ____YES ____NO

_____ _____

Client Signature Date

FINANCIAL AGREEMENT

I understand that the fees for the services to be provided are estimated to be approximately:
(check one)

____ $_1650__ Standard Evaluation (without attention measures)
____ $_1950__ Comprehensive Evaluation (with attention measures)
____ $_2550__ School Neuropsyc Evaluation (4 to 6 days of testing)
____ $_____ Other: _____

Attach a check made payable to: Susan B. Hill, Ph.D. or provide Credit Card at the first test session.

I understand that fees are due at the time of testing, and that I assume responsibility for payment of Dr. Hill's fees. I understand that I will be provided with an itemized statement with the written report for insurance or tax purposes. I understand that Dr. Susan Hill will not accept responsibility for collecting insurance reimbursement nor for second party collections or fees for returned checks. Further, it is understood that Dr. Hill has the right to retain an outside agency for collection of unpaid fees.

PARTY RESPONSIBLE FOR PAYMENT: _____

Signature Date

PERMISSION FOR TRAINEES

I hereby give permission for individuals who are being trained in assessment to observe testing, and understand that professionals who have obtained provisional licensure from the state of Texas and are completing the postdoctoral fellowship year under Dr. Hill's supervision may observe and administer tests, as well as interpret and report results. _____ YES _____ NO

_____ _____

Client Signature Date

PERMISSION TO USE DATA FOR RESEARCH

I authorize Dr. Susan Hill to use my data (e.g. test scores, developmental history, etc.) for research purposes. I understand that no identifying information will be used in reporting the research findings. Authorized personnel and other professionals on the research team may have access to the data for research purposes only. _____ YES _____ NO

_____ _____

Client Signature Date

CONSENT AND CONFIDENTIALITY

(please ask if you have any questions)

____ ____ Yes No I have read and understand services and fees (available on Dr. Hill's website: www.testing4kids.com). I understand my permission for testing and agreement to payment is required; however, I have a right to refuse to sign authorization for research and/or release of information without negative consequences to services.

____ ____ Yes No I have received and carefully read (available on Dr. Hill's website: www.testing4kids.com) the information regarding confidentiality (Privacy Procedures) and informed consent.

____ ____ Yes No I have been fully informed and understand the request for my consent, as described in the above sections.

____ ____ Yes No I understand that my consent is voluntary and may be revoked at any time, except as noted in the Privacy Procedures. In order to revoke my consent, I must provide a written request specifying the consent that is to be revoked.

____ ____ Yes No I understand that some of the tests and rating scales are collected and processed through the electronic system of Pearson Assessment. Adherence to Privacy and security regulations are in place to protect data and personal information.

____ ____ Yes No I understand that if I would like Dr. Hill to share information with other professionals (e.g. pediatrician, school, etc.), then I need to provide written permission. A Release of Information form is available on Dr. Hill's website.

_____ _____

Client Signature Date

Name: _____

Briefly describe challenges related to school:

_____
_____
_____

Have you received formal accommodations in the past? If so, please note when and what.

_____
_____
_____

Are you seeking accommodations or assistance at school? If so, please specify what you think would be helpful and why.

_____
_____
_____

Please check all that apply as a challenge:

___ Completing homework

___ Managing time & organization

___ Test-taking – multiple-choice

___ Test-taking - essay

___ Studying effectively

___ Specific academic subjects (e.g. reading, foreign language, math, etc.), specify _____

___ Social aspects

___ Other: _____

Additional Comments:

_____
_____
_____