205 Ridgedale Ave suite 101
Florham Park, NJ, 07932
973-660-0700
www.behavioralcarenj.com

INFORMED CONSENT

PURPOSE OF EVALUATON: Dr. Dranoff has been asked to perform a comprehensive psychological evaluation that will provide information about your child's cognitive functioning and ability to learn in school. This form was written to give you information about this assessment process and to assure that you understand the nature and purpose of the evaluation prior to beginning. This informed consent document is for the sole purpose of informing you about the process of a psychological evaluation and to differentiate this process from a traditional psychotherapy session. The session will be completed in approximately three sessions and will consist of Dr. Dranoff conducting a clinical interview with you, a collateral interview with anyone you chose, and formal psychological testing with your child. The information that you provide during the interview and psychological testing is confidential unless you sign a release for me to release information in your records. Furthermore, although this evaluation may provide valuable information about your child, it may not be helpful in obtaining services such as an Individualized Education Plan (IEP), admission into private school, or disability payments.

CONFIDENTIALITY: This evaluation is confidential and adheres to the tenets of the Health Insurance Portability and Accountability Act (HIPPA). Although this evaluation is confidential, Dr. Dranoff is legally and ethically required to notify outside organizations such as Child Protective Services, Adult Protective Services, Emergency Response, or Law Enforcement under certain conditions. Please read and initial the following statements indicating that you understand the conditions that require Dr. Dranoff to break confidentiality.

- If your child threatens to harm themself, someone else, or the property of others, Dr. Dranoff may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm.
  - INITIAL_____
- If any of your children are victims of child abuse, or if you divulge information about such abuse, Dr. Dranoff is required by law to report this to Child Protective Services or other appropriate authorities.
  - INITIAL_____
- If you or any of your adult family members are a victim or perpetrator of dependent or elder abuse, or if you or any of your family members divulge information about such abuse, Dr. Dranoff is required by law to report this to Adult Protective Services or other appropriate authorities.
  - INITIAL_____
- If the records from this evaluation are court-ordered by a Judge to be released, Dr. Dranoff is required by law to release these records.
  - INITIAL_____

OVERVIEW OF EVALUATION PROCESS: On the first day of the evaluation, you will meet with Dr. Dranoff for approximately 3 hours. The first part of the evaluation will consist of a clinical interview where you will discuss various areas of your child's developmental, academic, and social history. Although Dr. Dranoff will try to be thorough when he interviews you, he may not ask about some areas or information that you believe are important. Please feel free to provide him with any information about your child's psychosocial history. If there are any questions that make you uncomfortable, please let Dr. Dranoff know so that your concerns can be addressed and resolved.

205 Ridgedale Ave suite 101
Florham Park, NJ, 07932
973-660-0700
www.behavioralcarenj.com

In the second part of the evaluation, Dr. Dranoff will be interviewing your child and giving him or her several standard psychological tests. Dr. Dranoff will discuss the instructions in detail when he gives your child each test and you will be able to ask questions and address any concerns prior to beginning. Dr. Dranoff will provide you with feedback about your child's performance on the testing but be assured that the conclusions of this evaluation will not be based solely on one source of data.

You will also be provided with an opportunity to authorize Dr. Dranoff to speak with other individuals or organizations that may have information about your child. With your verbal and written permission, Dr. Dranoff would be able to contact family members, friends, co-workers, or medical providers who can provide him with information about your child. Dr. Dranoff will only contact these people with a sign release form and will not provide any information that is not authorized.

EMERGENCY PROCEDURES. If you need to contact Dr. Dranoff, you may call (973) 660-0700 and leave a message. Dr. Dranoff checks messages on a regular basis and your call will be returned as soon as possible. Phone time is extremely limited and reserved for emergencies and appointment scheduling. Please consider leaving a message on Dr. Dranoff's voice mail about important information whenever possible. In a life-threatening emergency, please call 911 or go to the nearest emergency room.

FEES FOR EVALUATION: A single charge is enacted for all professional time expended in the completion of this evaluation. This includes but is not limited to clinical interviews, review of records, telephone consultations, report preparation and report writing. A retainer of _____ is required, which represents the entire fee for the completion of the evaluation. Please note that this fee must be paid to the The Behavioral Care Center of New Jersey prior to the beginning the evaluation. If Dr. Dranoff is subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. All court-ordered activities will be billed at a rate of _____ per hour.

CONCLUDING REMARKS AND CONSENT

I have read this information statement and understand the nature of this psychological evaluation. I consent to Dr. Dranoff's credentials as the evaluator and my questions have been addressed adequately. I hereby agree to allow my child to participate in a psychological evaluation with Erik Dranoff, Ph.D. and to cooperate to the best of my ability, as shown by my signature below.

_____ _____
Printed Name of Patient/Client/Authorized Representative Date

_____ _____
Signature of Patient/Client/Authorized Representative Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested

_____ _____
Signature of Erik Dranoff, Ph.D. Date