Tiffany Griffiths, Psy.D. & Associates, Inc.

Consent for Testing of a Child

Name of child client (13 years of age or younger):_____

This is to certify that I give permission to Tiffany Griffiths, Psy.D. & Associates, Inc. to evaluate my child's psychological, learning/educational, neurological, social, and/or adaptive functioning. I understand that my child's case may be discussed during peer consultation meetings and as necessary with other licensed colleagues for consultation purposes. Identifying information will not be used so as to protect my child's privacy in these cases.

My child will be treated with respect and honesty throughout the evaluation process. I understand that unless this evaluation is being ordered by an attorney or school district payment for services is my responsibility and a report will not be released until payment in full is received. Tiffany Griffiths, Psy.D. & Associates, Inc. also reserves the right to use appropriate agencies to collect delinquent payments after 90 days and I understand that I will be responsible for any fees incurred for returned checks and/or the fees of such agencies.

While under most circumstances all communication between the client and evaluator is confidential, Pennsylvania State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency. It has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have had suicidal thoughts and desires. Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-evaluator relationship is made. Furthermore, if a third party such as a medical doctor, attorney, or school district requests the evaluation it will not be released until I sign a release of information (consent) form. I do understand that in order for the above evaluators to gain as broad of an understanding of my child's needs they do need to rely on collateral sources such as my child's teachers and pediatrician for their feedback. I consent to the gathering of information from these sources as well as other sources (to be identified) deemed necessary for the purposes of this evaluation.

_____ ____/____/____
Signature of parent/guardian Date

*_____ ____/____/____
Signature of parent/guardian Date

*Please note that if the child's parents are separated or divorced we require the signature of both parents if there is joint legal custody.