SIGNATURE FORM

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

PERMISSION FOR TESTING

I hereby give permission for an individual study to be made of my child's abilities and learning potential. I understand that this study may involve examination of records and reports (provided by the parent or sent at the request of the parent), gathering of developmental, educational, and social information, and will include individual testing. Some communication may be through email. 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 the parent/guardian.

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 the 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 AND are you the legal guardian of this child?
____YES ____NO

Both Parents/Legal Guardian's Signature is REQUIRED; if sole custody, a copy of the custody agreement is required.

_____ _____ _____
Parent One Parent Two Date

FINANCIAL AGREEMENT

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

____ $_2200__ Standard Evaluation (without attention measures)
____ $_2600__ Comprehensive Evaluation (with attention measures)
____ $_3400__ School Neuropsyc Evaluation (4 to 6 days of testing)
____ $_____ Other: _____

$400 Non-refundable Deposit is required to hold testing appointments.

Provide email to send Invoice for deposit: _____

The deposit will be applied to the full balance owed for the evaluation.

Attach a check made payable to: Susan B. Hill, Ph.D. or provide Credit Card at the first test session to pay for remaining balance. I understand that remaining fees are due at the time of testing, and that I assume responsibility for payment of Dr. Hill's fees. 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

Please check here ____ if you need an Itemized Statement with the written report for insurance or tax purposes. Dr. Susan Hill does not bill insurance companies and will not accept responsibility for collecting insurance reimbursement nor for second party collections or fees for returned checks.

CONSENT AND CONFIDENTIALITY
(please ask if you have any questions)

____ Yes ____ No I understand that some of the tests and rating scales are collected and processed through the electronic system of Pearson Assessment. On occasion, spoken responses may be temporarily recorded for scoring purposes and then deleted. 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.

____ 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 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.

_____ _____
Signature of Parent/Guardian Date

PERMISSION TO USE DATA FOR RESEARCH
I authorize Dr. Susan Hill to use my child's 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

_____ _____ _____
Parent One Parent Two Date

WRITTEN REPORT

Check below if you have a preference for receiving the written report:

_____ via standard mail

OR

_____ via email (report is password protected, but understand risks involved with digital transmission)