Client # _____ Client Initials _____

INFORMATION AND CONSENT FOR A PSYCHOLOGICAL ASSESSMENT
SIU CLINICAL CENTER

I do hereby give permission for a psychological assessment to be conducted by the Clinical Center for myself or my child (name) _____, and whose date of birth is _____. I understand that all of the information collected from me and/or my child during the psychological assessment will be confidential and that no information or records concerning the assessment will be divulged to any person without prior consent of individual receiving the assessment or their parent/guardian. This information can only be disclosed to someone else when I provide the Clinical Center with specific written permission to do so or as provided in the Illinois Mental Health and Developmental Disabilities Confidentiality Act (the "Act"). Some examples of legal disclosure without consent under the Act are when there is (1) suspected child abuse or neglect or both, (2) suspected elder abuse, (3) a danger to my child, myself/himself/herself, or others, (4) a court order to disclose information, or (5) a suit filed for breach of duty against the Clinical Center or one or more of its employees.

I understand that the assessment will be completed by appropriately trained graduate clinicians under the direct supervision of faculty licensed clinical psychologists.

I understand that if I am the parent of a child receiving an assessment and the child is under age 12, I must be onsite at the Clinical Center for the entirety of all testing appointments. I cannot leave the Clinical Center for any period while my child is receiving services.

Psychological evaluations at the Clinical Center may involve virtual or remote appointments. possible. For example, measures that can be administered over the phone or over video conferencing (i.e., Zoom) may be administered remotely. Please read the following statements regarding video conferencing:

- There are potential benefits and risks of video conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- For the purpose of confidentiality, you will need to be in a quiet, private space free of distractions during appointments. Appointments cannot be held in non-private spaces such as cars, restaurants, or offices where others can overhear the appointment.
- Sessions will not be recorded without the permission from the others person(s).
- You need to use a webcam, smartphone, or telephone during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- A safety plan that includes at least one emergency contact and the closest emergency room to your location will be created to be used in the event of a crisis.
- Signing below indicates your consent to receive Zoom links for your virtual appointments via this email: _____

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Payments for psychological assessments are made in two amounts. The first half of payment is due prior to the first appointment (remote or in person). The remaining assessment balance must be payed prior to the assessment feedback session where you will receive the copy of the assessment report. Payments can be made by calling the Clinical Center (618-453-2361).

In response to the COVID-19 pandemic, the Clinical Center may enact specific policies regarding safety precautions for in-person assessment appointments. Signing below indicates that you agree to the following:

- I understand that due to safety precautions the Clinical Center may implemented in response to the pandemic, there may be limitations to what information can be obtained during an assessment at this time and some measures may be administered in a non-standardized manner.
- I understand the safety precautions the currently enacted by Clinical Center and agree to follow them.
- I understand that despite the safety precautions, there is still a risk that I could contract COVID-19. I have considered my or my child's health risk before proceeding with the assessment and accept all potential risks.

Please print and sign your name on the lines below to indicate that you have read, understood, and agree to the terms of this consent form. Parents or guardians of minor children, please give your permission for treatment by signing on the appropriate line. Please ask for clarification if you have questions.

_____	_____	_____	☐
Client's Name (print)	Client's Signature	Date	Verbal Consent

_____	_____	☐
Parent/Guardian Signature	Date	Verbal Consent

_____	_____
Witness Signature	Date

Updated: 3/2023