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

502 N. Blakely St.	406 N. State St.	1251 Wyoming Ave.	1031 Main St.
Dunmore, PA 18512	Clarks Summit, PA 18411	Exeter, PA 18643	Peckville, PA 18452
(570) 342-8434	(570) 342-8434	(570) 654-4357	(570) 342-8434

CONSENT FOR TESTING FORM

This is to certify that I give permission to Tiffany Griffiths, Psy.D. & Associates, Inc. to evaluate my psychological, learning/educational, neurological, social, and/or adaptive functioning. I understand that my case may be discussed at peer consultation meetings and as needed with other licensed colleagues for consultation purposes. In these cases, identifying information will not be used so as to protect my privacy. In addition, I understand that my case will be discussed between Dr. Griffiths, the psychologist conducting the testing, and, if applicable, my therapist and prescribing physician/nurse practitioner in order to coordinate care.

I will be treated with respect and honesty during the evaluation process. I understand that unless this evaluation is being ordered by an attorney or school district that 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 the 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 or school district requests the evaluation it will not be released until I sign a release of information (consent) form. I do understand that if this evaluation is being ordered by a third party the above evaluators will need to contact collateral sources in order to gain a broad understanding of my needs. I consent to the gathering of information from these sources, which will be identified.

A copy of this authorization shall be considered valid.

_____

Signature of Responsible Adult(s) or Adolescent 14 years or older

_____

Date