

*Maura Abate, Ph.D.*

Licensed Psychologist + Child Neuropsychologist

Newburyport, Massachusetts



978-499-0509

**Consent and Agreement for Neuropsychological Testing or Psychological Services**

I, \_\_\_\_\_, agree to allow Maura Abate, PhD to perform the following services:

\_\_\_\_\_ Neuropsychological Evaluation (includes testing in the areas of intelligence, attention, memory, organization, academic achievement, personality and/or social emotional functioning)

\_\_\_\_\_ Preschool Evaluation

\_\_\_\_\_ Reading Evaluation

\_\_\_\_\_ Math Evaluation

\_\_\_\_\_ Attention Disorder Evaluation

\_\_\_\_\_ Psychoeducational Evaluation (intellectual and academic testing only)

\_\_\_\_\_ Psychological Evaluation (intelligence and personality testing only)

\_\_\_\_\_ Personality Evaluation

\_\_\_\_\_ Counseling

\_\_\_\_\_ Consulting

This agreement concerns \_\_\_\_\_ myself or my child, \_\_\_\_\_.

I understand that the fee for this service will be \$ \_\_\_\_\_ which is payable in \_\_\_\_\_ installments. An initial fee of \$ \_\_\_\_\_ is due at the intake interview where a history is taken. A deposit of \$ \_\_\_\_\_ is due at the time of testing and a final payment of the balance of \$ \_\_\_\_\_ is due on the completion and delivery of the report. I understand that I am fully responsible for payment of these services.

Or / My fee is \_\_\_\_\_ per hour for counseling/consulting payable at the time of service.

I also understand that the psychologist agrees to the following:

The procedures for selecting, giving and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association.

\_\_\_\_\_  
Signature of client, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of psychologist

\_\_\_\_\_  
Date