MICHELLE BARRATT PSYCHOLOGY

Practice Specialising in Children, Adolescence, Adult and Couples Therapy
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PRIVATE AND CONFIDENTIAL INFORMATION

STRICTLY FOR THE INTENDED RECIPIENT ONLY.
IF YOU RECEIVE THIS REPORT AND ARE NOT THE RECIPIENT PLEASE RETURN TO SENDER IMMEDIATELY OR SHRED.
NOT PERMITTED TO BE SHARED OR COPIED.

CONSENT FORM - FOR ASSESSMENTS TO BE PROVIDED & PAID

1. **I (CLIENT NAME or PARENT NAME) _____ provide full consent** for my Practitioner **(NAME OF PRACTITIONER YOU PROVIDE CONSENT TO)** _____ to administer the following assessments either face to face or via Email to myself and or my child/adolescent (If child or Adolescent, please Name) _____, and
2. Acknowledge that the cost of the Assessments to be administered has been discussed with me, and
3. In order to proceed with the Assessment Phase, I will need to pay 50% of the Assessment Fees at the time of booking the appointments required to administer the assessments.
4. That I have committed to paying the rest of the 50% Fee (The fees will be sent via invoice) 1-3 days prior to the Assessment Appointments. I understand that the Assessment Report cannot be provided unless all fees for the 'Assessment and or Report' have been paid for in full.
5. I also acknowledge that there is a Report Feedback Session that I will need to pay for, that is separate to the Assessment Administration Fee/Written Report:

ASSESSMENTS AGREED TO BE ADMINISTERED:

1. _____
2. _____
3. _____
4. _____
5. _____

Name of Client or Parent: _____

Signature: _____ DATE: _____

NAME & SIGNATURE OF PSYCHOLOGIST/ALLIED HEALTH PRACTITIONER ADMINISTERING ASSESSMENTS:

Name of Psychologist/Allied Health Practitioner (PRINT NAME): _____

Signature: _____ DATE: _____