Dr. John Carosso, Psy.D. & Associates, Inc.

Community Psychiatric Centers / Autism Center of Pittsburgh / Dyslexia Diagnostic & Treatment Center

CONSENT TO TREATMENT AND RELEASE OF REPORT

My signature below attests that I give consent for my child to be seen by **Dr. John Carosso, Licensed Psychologist**, and Dr. Carosso's Practice Associate from Dr. Carosso & Associates, and/or from Community Psychiatric Centers for a psychological and/or psycho-educational evaluation of my child.

Psychological Evaluation of my child: _____

I understand that Dr. Carosso will conduct an evaluation of my child for the presenting problem(s) in accordance with ethical principles and research-based best practices. In this regard, an 'evaluation' will consist of a clinical interview of my child, a review of the developmental history with me (the parent), and the 'testing' process may include an assessment of intelligence, academic skills, visual-motor functioning, developmental levels, language, sensory issues, and social-emotional functioning.

Dr. Carosso may also reach out, with my signed consent, to others who have contact with my child, such as his/her teacher or therapist. I understand that the evaluation process will conclude with Dr. Carosso providing his clinical opinion regarding the formulation and diagnosis. I understand that Dr. Carosso will thoroughly explain his rationale for the diagnosis and treatment options and will work at length to ensure that I'm on the same page' in that respect. However, I understand I may or may not agree with his opinion and I understand that I can get a second opinion if I so choose. I also understand that Dr. Carosso prioritizes providing clear and concise feedback regarding a diagnosis and course of treatment, but I also recognize that he may not offer a final diagnosis at the time of the evaluation pending his reaching out to my child's teacher or therapist for further information. Dr. Carosso may also provide suggestions in terms of a course of treatment, and I realize I may not agree or wish to pursue the suggested treatment, and I recognize it's up to me, as my child's parent, to ultimately make such treatment decisions.

I acknowledge that I am having my child seen by Dr. Carosso for an evaluation, not specifically for counseling or therapy. During the evaluation process, various treatment options will be discussed, and I may decide to obtain therapy for my child; Dr. Carosso can help facilitate the process of finding a therapist. Depending on the issues at hand, Dr. Carosso may discuss outpatient counseling, or in-home or in-school services. If I wish to immediately pursue outpatient therapy while waiting for the evaluation, or forego an evaluation in favor of simply beginning outpatient therapy, I understand I can reach out directly to his office at 724 850 7200 to make such arrangements.

I understand that Dr. Carosso has produced abundant content including posts and his eBooks, available at HelpForYourChild.com, for the purposes of providing parents with helpful information to assist in managing their child's behavioral and developmental challenges. I also understand that Dr. Carosso may provide a referral for treatment services, if such is indicated, those treatment services typically would include in-office outpatient counseling, IBHS in-home or in-school services, in-home Family Based services, or a Social Skills Group.

I am aware that Dr. Carosso, Psy.D. has a doctorate in the field of Psychology, is licensed as a Psychologist in the State of PA (www.psychologyinfo.com/directory/PA/board), and has over 30 years of experience in the field working with children and teens. He has a Certification in School Psychology, a Graduate Certificate in Applied Behavioral Analysis in Special Education, and a Graduate Certificate as a Trauma Specialist. He specializes in evaluating and providing treatment for children and teenagers but also has extensive experience in providing evaluations and treatment of adults and does so on a regular basis. Dr. Carosso works in private practice (**Dr. John Carosso, Psy.D. & Associates, Inc**) is a partner at the mental health agency, **Community Psychiatric Centers**, and partner at the **Autism Center of Pittsburgh.**

Confidentiality and Release of Report

I am aware that the evaluation will be provided in an atmosphere of trust and, as such, all information will be kept confidential. However, I am aware that the evaluation report containing clinical information will be sent to relevant agencies including the child's pediatrician. If in-home or in-school treatment services are requested, my signature below reflects my understanding that the report will need to be submitted to the relevant County Behavioral and Developmental Unit to begin services. I am aware that Dr. Carosso will discuss these issues (where the report needs to be sent and will obtain your approval) prior to submitting the report to any outside entity or person. I am aware I can make Dr. Carosso aware of any specific pieces of information that I do not want to be included in the final report or if I do not want the report released. I am aware that I have access to my HIPAA privacy rights.

My signature below reflects my awareness that, in the case of my child or I presenting as a danger to self or others, or in the case of child abuse, that this information will need to be disclosed to the proper authorities. However, I have been informed that these issues may first be discussed with me before being disclosed to relevant others.

Costs for Services

I understand the fee arrangements and that an "evaluation" can range in cost from $80.00 (a clinical interview) to $800.00 or more (for a clinical interview and psychological/psycho-educational testing). I understand that my insurance will be billed; out-of-pocket payment will be discussed and agreed upon prior to evaluation. I give permission for Dr. John Carosso to bill my insurance company, and/or the funding source, and I understand that I am responsible for paying if the evaluation is not covered by insurance, and/or the co-pay, that will be billed after the evaluation. I understand the importance of checking with my child's insurance company prior to the evaluation to ensure coverage.

Appointments and Emergencies

I am aware of the importance of keeping the appointment and, if I cannot attend the evaluation, to provide at least 48 hours' notice. In case of emergencies, I have been informed to contact **911**; and that I can also contact the Practice of Dr. Carosso, at any time, at **724-787-0497**. If there is no answer, I have been informed to leave a message on voice mail (picks up after five or six rings) and the call will be returned as soon as possible.

_____ _____

Signature Date

_____ _____

Signature Date