Therapeutic Time, Inc.

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Consent for Psychological Testing

Sarah Barajas, MA, Psychological Associate PSB 94027905
Liliana Chavez Weichold, MA, Psychological Associate PSB 94027514
Dr. Trisha Rich-Thurm, PsyD, Licensed as a Clinical Psychologist PSY 24976,
Marriage & Family Therapist MFC 42603, & National Certified Counselor NCC 264935
therapeutictimeinc@therapyemail.com / Phone 661-714-2082 / 1043 West Ave, M4 Suite B Palmdale CA 93551 /Fax 661-466-2029

I, [name of patient]_____

By signing this document, I hereby authorize (check one):
☐ **Dr. Trisha Rich-Thurm, Clinical Psychologist PSY 24976**
☐ **Liliana Weichold, MA, Psychological Associate PA# PBS94027514**
☐ **Sarah Barajas, MA, Psychological Associate PA# PSB 94027905**

The provider selected the right to perform Psychological Testing and to document the results and findings of such testing for information gathering and for disclosure for the following purpose: (please circle)

Billing Purposes Diagnosis Resource Supports Coordinate Care Other

_____

Such testing shall be performed with the following: informed consent of the nature and risks of the testing, how the information will be used, testing, scoring, and documentation of the findings will be supervised, and testing will be limited to the specific types of information necessary for the identified purpose as indicated above.

Treatment Dates: Possible Diagnosis: _____

Testing Provided: _____

Treatment Goals: _____

***I understand that any cancellation of this authorization must be in writing.** **This authorization shall remain valid **until a year from this date**.

*Signature [of the patient, parent, or guardian]: **Date: Date of Birth [of patient]:

_____ _____