Ildiko Tabori, PhD

Psychologist

CA PSY19688

Informed Consent – Evaluation/Testing

I, _____, give my informed consent for psychotherapeutic treatment and/or psychological and/or neuropsychological assessment to Ildiko Tabori, PhD, a licensed psychologist in the State of California. _____ (Initial)

I understand that my medical/mental health information cannot be disclosed without my written consent under any circumstances, except in emergency situations wherein I am:

- A danger to myself
- A danger to others
- Disclose child, elder or dependent adult abuse _____ (Initial)

I understand the payment arrangement I have made to be as follows:

Insurance

- If medical insurance is involved, the Office of Dr. Ildiko Tabori will check the eligibility and benefits only as a courtesy to me and will bill my insurance carrier only as a courtesy to me. I am still fully responsible for all fees and charges that my insurance carrier does not cover or pay, including any and all co-pays, out of pocket expenses, and deductibles. _____ (Initial)
- Evaluation/Testing is not always authorized by insurance carriers and typically require authorization based on medical necessity. Authorization is solely at the discretion and/or determination of the insurance carrier. The Office of Dr. Ildiko Tabori will submit for authorization as a courtesy to me. _____ (Initial)

Evaluations / Testing

- The fee for a standard psychological evaluation is $2,250.00, to be paid in full at the conclusion of each testing session unless prior arrangements have been made, Such as **billing primary and secondary medical insurance or other agreed upon fee if authorized.** _____ (Initial)

- The fee for a standard neuropsychological evaluation is $2,500.00, to be paid in full at the conclusion of each testing session unless prior arrangements have been made, Such as **billing primary and secondary medical insurance or other agreed upon fee if authorized.** _____ (Initial)

- I understand that this fee may vary depending upon the type of evaluation required and that the fee will be quoted prior to the onset of the evaluation. _____ (Initial)

Cancellation Policy

- I understand that scheduled appointments that are not cancelled with at least a 24-hour notice are billed at the rate of $80. No shows for scheduled appointments are also billed at $80. There is no charge for sessions with at least 24-hour notice. _____ (Initial)

Signature:_____ Date:_____

Name (please print): _____