Atlanta Area

Family Psychiatry Clinic, PC

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Child, Adolescent, Adult and Family
Psychotherapeutic Services
www.AAFPC.net

INFORMED CONSENT FOR COURT RELATED SERVICES

1. Court Ordered/Related Services

I understand that the Robert M. Slayden, M.D. of the Atlanta Area Family Psychiatry Clinic, P.C. has been Court appointed or agreed upon by mutual consent by the parties involved. I understand that Dr. Slayden is independent from all parties involved, and does not work for me, for my attorney, for any attorney involved in the case at hand or for any other party to the dispute. I understand that the Dr. Slayden of Atlanta Area Family Psychiatry Clinic, P.C. will provide information to the Court. The type of information the Court is requesting often relates to the best interests of child(ren), but may also involve other issues. The type of information requested is often referred to in an order issued by The Court.

2. Waiver of Confidentiality

I understand that information I share with the professional(s) at Atlanta Area Family Psychiatry Clinic, P.C., is generally not confidential in this case only. I understand that, unless otherwise specified, a report summarizing data and impressions will be sent to the Court, the attorneys, and adult parties to this dispute. This report will contain information regarding the members of my family and possibly other significant people involved with my family. I understand that the attorneys involved in the case may have the right to request access to all of the notes of the evaluator(s), and other sources of information. I understand that despite these probable limitations of confidentiality, the evaluators want me to express specific concerns that I may have about any of the information being shared, including possible detrimental effects that revealing the information may have on me or my child(ren).

3. Availability

I understand that the services provided by Atlanta Area Family Psychiatry Clinic, P.C., have been Court ordered or has been agreed upon by mutual consent by the parties involved and that I will be expected to make myself and my child(ren) available to be interviewed, observed, and given any psychological tests deemed necessary by Dr. Slayden. I understand that the evaluator(s) will conduct as comprehensive an evaluation as they consider necessary to collect sufficient information. I understand that I must make available any materials the evaluators think could be useful and pertinent, and that I must turn in all required paperwork requested at the commencement of services. If there are other people who play an important and ongoing role in my child(ren)'s lives, I understand that the evaluators may interview them, and, depending on their relationship with me and my child(ren), involve them in other parts of the evaluation.

4. Outcomes

I understand that Atlanta Area Family Psychiatry Clinic, P.C. has been Court ordered or has been agreed upon by mutual consent by the parties involved to provide services. I understand that while outcome of these services may be positive, there are no guarantees that this will be the case. I also understand that there may be risks involved, including that I and/or other family members may experience stress and anxiety, that I may have to reveal information that I would prefer to keep private, and that the outcome of the evaluation may not be to my liking. There may also be other risks specific to my situation. I understand that whatever the outcome of the evaluation, the Court is under no obligation to accept the data, assessment, and/or recommendations provided in the report to the Court.

5. Releases of information

I understand that I must sign releases of information for any professionals I or my child(ren) have had professional contact with if the evaluator(s) think that the information the professional would provide may prove to be useful or pertinent.

6. Attorneys

I understand that I have the right to consult with my attorney at any time, for any reason, and that I can ask to temporarily postpone appointments, and temporarily postpone signing agreements and releases of information until I have consulted with my attorney.

7. Reports

I understand that at the completion of the evaluation, I will be provided with a copy of any reports Atlanta Area Family Psychiatry Clinic, P.C. prepares for the Court after it has been provided to The Court or is presented in court. I understand that the contents of the report are not to be discussed with or shown to my child(ren). I understand that my child(ren) should not be questioned about statements they made that appear in the report. I understand that telling my child(ren) about the report or its recommendations before there is a final Court Order in effect could be quite detrimental to them. I understand that there may be times when the evaluators may decide that it would be appropriate to give feedback to selected child(ren). If this is the case, they will discuss this with me prior to meeting with my child(ren). By signing this document I agree to not discuss the specific contents of the report, share the contents, or show the report to my child(ren).

8. Signed agreements

I understand that I am required to sign three documents:

1) This Informed Consent, 2) Fee Agreement, and 3) Custody Evaluation Questionnaire.

I understand that the evaluation will not proceed until all parties to this Court action sign all three agreements.

I have reviewed the foregoing information and understand the contents. By my signature, I hereby

approve and consent thereto:

_____	_____	_____/_____/_____
Signature	**Printed Name**	**Date**