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INFORMED CONSENT FOR THE APPLICATION OF NEUROPSYCHOLOGICAL/ PSYCHOLOGICAL TESTING PROCEDURES

Procedure: Neuropsychological Evaluation

Nature of Procedure: You/your child were referred for neuropsychological evaluation by _____. The evaluation may include, but may not be limited to, a clinical interview of you, your child, and your closest family member(s) and/or significant other(s), standardized tests of cognitive, behavioral, sensory, motor, personality, and emotional functioning, with specific tests chosen to fit individual circumstances. It is important that you accurately report your child's history and symptoms. You should not minimize any difficulties that your child has, nor should you try to over-emphasize your child's difficulties. The tests your child will take are designed to measure a wide range of abilities. Some will be difficult, and some will be quite easy. Your child's evaluation is being conducted by a licensed psychologist with specialty training in neuropsychology.

It is important that your child put full effort into all tasks so that the examiner can obtain an accurate assessment of your child's current strengths and weaknesses, and because the examiner will be continuously assessing your child's level of effort to determine the validity of the evaluation results. If at any point during the evaluation the examiner feels your child is not putting full effort into the testing, the evaluation may be terminated, and may not be rescheduled. Results of any tests completed to that point will not be interpreted, as insufficient effort makes test results uninterpretable. You understand that if this occurs, it may impede your ability to obtain or retain disability benefits, and/or compensation in legal claims for your child. Even if the evaluation is terminated, you will be charged for the amount of time you and your child spent with the neuropsychologist up to that point.

Today's evaluation is expected to take about _____ hour(s) of your time, though this may vary upwards or downwards, based on your child's performance as the evaluation progresses. After the testing is completed, the neuropsychologist will spend approximately 50% more time scoring your child's tests, interpreting them, and preparing the results. You may receive the results of your child's testing the same day, or you may be asked to return for a follow-up visit in 1-2 weeks to receive your results.

Intended Purpose of Procedure: To obtain information about current strengths and weaknesses across the above ability areas, and to clarify brain-behavior relationships. This information will be used to give opinions and make recommendations concerning diagnosis, treatment, rehabilitation, job or school functioning, ability to drive, ability to live independently, and/or the need for further evaluations. Test scores and general historical information may be used at a later time in professional papers, presentations, and/or publications, though the identity of the tested individual will be protected. The report generated from this evaluation is intended for clinical purposes only (i.e., assessment, diagnosis, and treatment planning), and is not intended for legal purposes.

Parent/Guardian Initials_____

Limits of Confidentiality: Information obtained during this evaluation is confidential, and can ordinarily be released only with the written permission of you or your child's health care power of attorney/guardian. If your evaluation costs are being submitted to a 3rd party for payment (such as health care insurance, workman's compensation company, vocational rehabilitation, etc.), this 3rd party may require receipt of results in order to cover the cost of your child's evaluation. Upon your request, with your written permission, we will forward results of today's evaluation to other individuals involved in your child's care (such as other doctors, schools or educators, disability determination services, attorneys, etc.). However, you understand that the results of this evaluation may or may not support your pursuit of disability benefits, liability claims/personal injury, etc. There are some special circumstances that can limit confidentiality, including: a) a statement by your child of intent to harm him/herself or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law.

Billing/Insurance Coverage: You will be expected to pay for services at the time they are rendered, unless we agree otherwise. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, those costs will be included in the claim. If you have a health insurance policy, it will usually provide some coverage for mental health treatment & testing. If your child has a medical diagnosis that impacts their cognitive, emotional & behavioral functioning often times neuropsychological testing will be covered under your medical benefits and not mental health benefits. While I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, you (not your insurance company) are responsible for full payment of my fees. It is therefore very important that you find out the extent to which my services are reimbursable through your insurance company.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator or human resources consultant.

You should also be aware that your contract with your health insurance company may require that I provide them with information relevant to the services that I provide to you in order for you to obtain reimbursement. Your account statement provides the information most commonly requested (e.g., clinical diagnoses, CPT codes, date of service, etc.) Your health insurance company may request additional clinical information such as treatment plans or summaries, or even copies of your entire record (although this is not common.) In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested and only upon your request. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance company.

Parent/Guardian Initials_____

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless expressly prohibited by your insurance policy.) Paying for my services yourself provides maximal privacy protection and control over the services you receive.

Risks Associated with the Procedure: There are no known physical risks. Generally, psychological and/or emotional risks are minimal and consist of possible temporary emotional discomfort (such as frustration or anxiety while working on more challenging procedures), and fatigue. A small number of individuals could experience greater emotional distress from becoming aware of limitations or areas of difficulty that may have been previously unknown to them, or from having to discuss difficult issues with the examiner.

I understand the above procedure, nature of the procedure, intended purpose, and potential risks as stated above. Any questions have been answered to my satisfaction. I understand that I can contact the neuropsychologist conducting today's evaluation at any time in the future should I have any questions about my child's evaluation. I freely agree to have my child take part in this procedure, and understand that I can terminate my child's participation at any time.

_____ _____

Patient Signature Date
(print name of patient if patient is a minor or has a legal guardian)

Signature of Guardian Date
(as applicable)

_____

Witness Signature Date

Parent/Guardian Initials_____

Parent/Guardian Initials_____