## Jill Brickman, Psy.D.

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CONSENT AND AGREEMENT FOR NEUROPSYCHOLOGICAL AND DIAGNOSTIC TESTING

Please type all information directly into the form and send it back to [jill.brickman@gmail.com](mailto:jill.brickman@gmail.com). Thank you!

**I. Description of Services**

I, Click or tap here to enter text., agree to allow Dr. Jill Brickman, Psy.D. and associates to perform the following services:

Psychological testing, assessment, or evaluation

Report writing

Consultation with school personnel (if applicable)

Other (describe): Click or tap here to enter text.

Other (describe): Click or tap here to enter text.

This agreement concerns  myself or  Click or tap here to enter text.

I understand that this evaluation is to be done for the purpose(s) of: **Assessment of learning needs and potential diagnoses, and recommendations for services, interventions, and accommodations.**

I understand that these services include an initial clinical interview with myself and/or my child, all face-to-face and computerized testing, review of records, consultations with other professionals, a written report explaining the results and recommendations, a feedback meeting to discuss the results, and one meeting with school or DOE personnel.

**II. Fees and Payments**

I understand that the fee for these services will be **$**Click or tap here to enter text. and that this is payable in two parts: (1) a deposit of **50%** payable at the start of these services, and (2) a second payment of the balance due on the completion of testing and prior to delivery of the written report. Though my health insurance may repay me for some of these fees, I understand that I am responsible for payment for these services as indicated. Dr. Brickman will provide a detailed receipt for services.

Additional meetings after feedback has been provided can be scheduled with an additional fee of $250/hour.

Payment can be made using QuickPay with Zelle (to [jill.brickman@gmail.com](mailto:jill.brickman@gmail.com)), in cash, or by check made payable to *Dr. Jill Brickman* and mailed to me at:

330 West 58th Street, Suite 203

New York, NY 10019

Please indicate your payment method: Click or tap here to enter text.

**III. Support Staff**

I understand that Dr. Brickman may share my information with other providers and/or business associates if necessary, including, but not limited to, student interns, my insurance company, or an outside billing agency.

**IV. Ethical Responsibilities**

I also understand that Dr. Brickman and associates agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.

2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.

3. Original tests and test results will be kept in a secure place to maintain their confidentiality for a period of one year after completion of the evaluation. After one year, all documents will be electronic copies.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

**V. Duty to Warn / Duty to Protect**

I understanding that if Dr. Brickman or her associates believe that I, or my child, am in any physical or emotional danger to myself or another human being, she has a duty to contact any person who is in a position to prevent harm to me or another, including, but not limited to, any medical or law enforcement personnel deemed appropriate and the person in danger.

**VI. Email Disclosure**

I understand that email is not a secure form of communication. Dr. Brickman and associates cannot guarantee the confidentiality or security of any information sent over email. Dr. Brickman shall not be liable for any breach of confidentiality resulting from such use of e-mail. I have the right to withdraw consent for email communications at any time.

**Typing my name below serves as a signature and acceptance of the terms and conditions of the above agreement.**

Click or tap here to enter text. Click or tap to enter a date.

Signature of client (or parent/guardian) Date