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CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

This consent form is to request the voluntary evaluation of _____
By Bonnie Connor, PhD.

Referral Source: You have been referred for a neuropsychological evaluation (i.e., evaluation of your memory and thinking abilities) by _____.

Nature and Purpose of Evaluation: The goal of neuropsychological evaluation is to help you, your treating providers, family, and qualified third parties gain a better understanding of your relative strengths and weaknesses, and any changes from how you were functioning previously. Evaluation is helpful in identifying specific diagnostic considerations, and treatment recommendations.

Neuropsychological tests are designed to evaluate brain-behavior relationships and help determine if any changes have occurred in your attention, memory, language, problem solving, visual-spatial abilities, or other cognitive functions. A neuropsychological evaluation may point to changes in brain function and suggest possible methods and treatments for rehabilitation.

Evaluation Process: In addition to an interview in which I will be asking you questions about your background and current medical symptoms, I may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, listening to recorded tapes, viewing printed material, and manipulating objects. True-false and self-report emotion and personality questionnaires will also be included. Supplementary records from hospitals, treating physicians, professional providers, schools, as well as interviews with designated family, care providers, and individuals who know you well may be included with your consent.

The interview typically takes 1-2 hours. Testing is usually scheduled on a different day. Depending on the referral questions, testing can range from as little as 2 hours to as much as 6 to 8 hours. You will be given breaks as needed and requested. Once the tests are administered, the data analyzed, and relevant records reviewed, the results will be incorporated into a written report that explains the test findings, diagnostic considerations, and recommendations. A post-test consultation will be scheduled with you, and anyone you choose to include, to discuss the results and recommendations.

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness about performance. Benefits associated with this assessment include gaining a better understanding of your current strengths and weaknesses, developing a plan to use your strengths to work with or accommodate your weaknesses, and identifying treatment that is specific to your needs.

Fees and Time Commitment: The hourly fee for this assessment is_____, unless a contracted rate is in place. A typical evaluation is comprehensive. It includes the time spent directly with you and others who are interviewed. It also includes additional hours for reviewing records, scoring and interpreting the tests, report preparation, and meeting with you for feedback, which will likely add 6 to 8 hours in addition to the direct testing time. This comprehensive evaluation process is estimated to take _____ hours of time.

Payment and Assignment of Benefits: Though the fees are generally covered by insurance, patients are responsible for any and all fees for the evaluation. By signing below I am authorizing payment of benefits to Dr. Bonnie Connor; payment of services is thereby directed to her. Dr. Bonnie Connor may need to send information to the insurer to obtain payment for this evaluation.

Confidentiality: The records concerning this evaluation will be retained by Dr. Bonnie Connor and will be kept confidential according to the California Welfare and Institution Code Section 5328. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of medical emergency, to secure payment for treatment from health insurance plan or other third party payment system, or as permitted by law. Under the following circumstances, the law requires or permits that information be disclosed:

1. When there is reasonable suspicion of child abuse or neglect, or evidence of elder or dependent adult abuse.
2. When a person presents an imminent or potentially serious danger to self or others.
3. In the event of certain court orders, including subpoenas for judicial arbitration or mediation.

Release of Information: By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party. In order to release information to individuals other than the referring party, you must sign a separate written consent form authorizing the release of the requested material to the designated party.

By signing this form, I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the described services and limitations of confidentiality.

_____

Patient Signature Date

_____

Parent/Guardian or Authorized Surrogate (if applicable) Date

_____

Witness Signature Date