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# CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

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

**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, treatment recommendations, and appropriate reasonable accommodation for academic and employment settings.

Neuropsychological tests are designed to evaluate brain-behavior relationships and help determine if there are weaknesses in your attention, processing speed, memory, language, problem solving, visual-spatial abilities, or other cognitive and emotional functions that might interfere with daily functioning, or with academic and employment success.

**Evaluation Process:** In addition to an interview in which I will be asking you questions about your background and current symptoms, I may use different techniques and standardized tests including but not limited to questions about your knowledge of certain topics, 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 may take 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 $150, 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, including post-test feedback session, is estimated to take a total of 16 to 20 hours of time.

**Payment and Assignment of Benefits:** Although the fees are generally covered by insurance, patients are responsible for any and all fees for the evaluation. For self-paying patients, one-half of the total cost of the evaluation is due at the initial appointment and the balance (one-half of the total cost) is due at the feedback session when I provide you with a report. Your insurance will billed, if requested, and reimbursement assigned to you. You may pay for the evaluation by check made payable to Dr. Bonnie Connor, or by credit card on my web site at the "Pay Now" button: http://bonnieconnor.com/for-patients/.

**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