



INFORMED CONSENT FOR OUTPATIENT NEUROPSYCHOLOGICAL SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING

Psychological and neuropsychological evaluations usually consist of an interview and testing. During the interview, information that is important for me to consider will be reviewed. Testing involves taking paper-and-pencil or computerized tests and answering questions. The time required depends on the problem being assessed. In general, 3-6 hours are needed to assess the many skills involved in processing information. Some tests will be easy while others will be more complex. The most important thing is to try your best. The detailed information that is gathered will contribute to your care.

PROFESSIONAL FEES

My hourly fee is \$250. In addition to our appointment, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. If a technician administers tests in my stead or provides other services you may need, the hourly fee for the technician is \$150.

BILLING AND PAYMENTS

You will be expected to pay for your evaluation at the time it is held, unless we agree otherwise or you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 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. If such legal action is necessary, its costs will be included in the claim. 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. NOTE: I am not paneled with Medicaid and it will not cover out of network benefits. You will be responsible for those charges.

INSURANCE REIMBURSEMENT

I will fill out forms and provide you with whatever assistance I can for you to receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what services your insurance policy covers. 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. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I will not answer the phone while I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please provide me with several times when you will be available. If you are unable to reach me and feel that it is an emergency, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep records of your evaluation for at least 7 years. You are entitled to receive a copy of your records, unless I believe that your seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see a copy of the report of your psychological or neuropsychological evaluation, I will review the results with you during a feedback session so that we can discuss the contents of the report. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. Occasionally, I use data gathered in the process of assessments for research purposes. When this occurs, all identifying information is first removed from individual files, then combined with other anonymous files. Research helps me to better understand the client population and the nature of the referrals that present in my practice.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your records. Before giving them any information, I will discuss the matter with you, if possible, and do

my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient’s treatment. For example, if I believe that a child, elderly person, or disabled person, is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations rarely occur in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together.

ACKNOWLEDGEMENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. The undersigned consents voluntarily to treatment and services and acknowledges that the results of any treatment or services by the psychologist have no guarantee or warranty. If the patient is under the age of 18, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment. *The undersigned has received a copy of this notice and authorizes the staff to leave a message regarding certain private health information (typically appointment reminders) on my voicemail/answering machine.*

_____ Date: _____

Patient Signature

Printed Name