The Brain Center
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Consent for Treatment
Adult Neuropsychological/Psychological Evaluation

A neuropsychological or psychological assessment (also referred to as neuropsychological or psychological testing or evaluation) usually takes considerable time on both of our parts, often over the course of several days or weeks. During the first session, we will discuss your current and past family and relationship history, any problems or symptoms you are experiencing, any past treatment and its outcome, and other general background information. Over the course of 1-2 meetings, we will do a number of different tasks together. You will probably also complete a number of forms and questionnaires on your own. When you have completed all the tasks, your clinician will review, score and interpret the results. Occasionally, your clinician will determine after reviewing some of the material that an additional test(s) would be helpful. If that is the case, we will call you to inform you of this. We schedule a feedback appointment approximately 2-3 weeks from the time of the last testing appointment to provide your clinician with enough time to complete scoring, interpretation, and report writing. It is important to understand that your clinician will not be engaging in psychotherapy with you when the psychological evaluation is being conducted. Nonetheless, your clinician still bound by the ethical and legal limitations and laws that any psychologist must follow.

Scheduling: Scheduling presents a special problem, because once testing time is blocked out, it typically cannot be filled again on short notice. As a result, we ask that you give us at least **48-hours'** notice if you need to cancel an appointment. Failure to do so (except in cases of serious illness or emergency) will result in you being billed a cancelation fee as outlined in the Office Policies form. Please be aware that fees for missed visits are not covered by insurance.

FINANCIAL AGREEMENT

General: In consideration of the neuropsychological or psychological evaluation being rendered to _____ (Name of patient) by my clinician, I, the undersigned, hereby agree to pay for services provided in accordance with the estimated cost of the evaluation as outlined below. I understand that my clinician bills an hourly rate for neuropsychological and psychological evaluations at the fee outlined in the office policies. This rate applies to all telephone calls to any other parties for whom I give my clinician permission to speak. I will also be billed for all time in which my clinician: meets with me to complete testing; reviews, scores and interprets the tests; writes the professional report; and meets with me to provide feedback about the results of the evaluation. The balance of the evaluation will be due at the last testing appointment (prior to scheduling feedback). My clinician cannot meet with me, nor complete the assessment, including feedback to myself or other professionals, until I have paid the full balance of our bill for the assessment.

For insurance clients: In some cases, my clinician may determine that additional testing could be useful that insurance does not cover. They will discuss this with me prior to completing more hours, and together, we will decide whether we will eliminate some of the tasks or agree to pay a higher cost. If I agree to further testing, my clinician will provide me with an amended financial agreement outlining the cost of the additional services. I understand that if the assessment takes considerably longer than usual, and I chose not to complete all the tasks rather than incur more expense, the assessment results may not be valid. My clinician will discuss what, if any conclusions, can be validly drawn from an abbreviated evaluation.

There are also times when insurance companies decide they will not pay for the cost of a completed evaluation based on certain diagnoses or if the evaluation results indicate I do not meet criteria for a mental health diagnosis. I understand that, even in these situations, I am ultimately responsible for the full cost of the evaluation.

I, _____, agree to participate in a neuropsychological or psychological assessment conducted by my clinician. I have been informed by my clinician of the nature of this evaluation, and I understand that a report will be written based on the results of the evaluation. My clinician has informed me that this is considered a medical record document that cannot be disclosed to third parties without consent, unless under special circumstances (e.g., possibility of harm to self or others, abuse or neglect of children or vulnerable adults, court-order). I understand that this testing is voluntary, and that I can choose to not be tested or to stop testing at any time.

My signature below indicates that I have fully discussed with my clinician the various aspects of our contract for a neuropsychological or psychological evaluation. My clinician has discussed with me scheduling, the nature of the fee and policies regarding missed appointments, and I agree to proceed with the evaluation.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits. _____
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees with collecting this bill. _____
Initial

I authorize communication between my clinician and referring physician/clinician _____ to inform that I have initiated services (separate release is required for further exchange of information). _____
Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐Telephone (please provide preferred number): _____

☐Voicemail Message _____

☐Text Message (if different than above):_____

☐Email: _____

☐Postal Mail (include address if other than provided): _____

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Signature Date

_____ _____
Witness Printed Name Date