NORTHEAST NEUROPSYCHOLOGY
BRAIN & BEHAVIORAL HEALTH PARTNERS

INFORMED CONSENT FOR THERAPY SERVICES & TELE-THERAPY

I, _____, hereby authorize and request Northeast Neuropsychology, LLC (NN) to conduct therapy with me. The goals, rationale and procedures have been explained to me.

I understand the issue of confidentiality and its limitations and these have been explained to me. I understand that this evaluation will be confidential. I understand that NN must adhere to legal and ethical standards in the management and communication of information related to this therapy and that NN will exert reasonable care to ensure as much as possible that access to this information will be provided to others only as appropriate.

I hereby authorize NN to release confidential information as needed to obtain payment from third party payors. I authorize and request NN to release any and all information, results, opinions, conclusions and recommendations related to this therapy only to those individuals identified on releases. This release can occur via print, fax, email, phone or in person. **I understand that I am responsible for payment for all therapy sessions in full in the event that insurance does not pay for it.**

I have received a copy of my rights regarding privacy of health information and any questions have been answered to my satisfaction. I understand that HIPAA does not apply in situations in which results of therapy are utilized by me in criminal or civil forensic matters and workers' compensation matters.

I understand that the providers at NN will use their best effort to address the referral question, but that no guarantees or promises can be made with regard to outcome of therapy.

I have read the above consent. I have had an opportunity to ask any questions regarding these issues and these have been addressed to my satisfaction. I understand and accept this consent.

_____ _____
Signature Date

_____ _____
Witness Date

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