NORTHEAST NEUROPSYCHOLOGY LLC
BRAIN & BEHAVIORAL HEALTH PARTNERS

INFORMED CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

For Parents, Caregivers or Conservators of Patients.

I, _____, hereby authorize and request Northeast Neuropsychology, LLC (NEN) to conduct a neuropsychological evaluation with _____, DOB_____.
(Patient Name)

The goals, rationale and procedures have been explained to me.

I understand that this evaluation will include interview of the patient and possibly me (and possibly others with my permission) and the administration of psychological and neuropsychological procedures designed to measure a range of cognitive, behavioral, personality/psychological, and emotional factors. I understand that assessment of motivation and effort is a standard component of neuropsychological evaluation. I understand that all procedures are important, even if their purpose is not always readily apparent.

I understand that the patient will be receiving feedback regarding this evaluation from NEN and/or their referring doctor. I understand that the purpose of this meeting is for evaluation only and that an on-going treatment relationship with NEN is not being established.

I understand the issue of confidentiality and its limitations, and these have been explained to the patient and me. I understand that this evaluation will be confidential. I understand that NEN must adhere to legal and ethical standards in the management and communication of information related to this evaluation and that NEN 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 NEN to release confidential information as needed to obtain payment from third party payors. I authorize and request NEN to release any and all information, results, opinions, conclusions, and recommendations related to this evaluation 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 the evaluation 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 neuropsychological evaluation are utilized by me in criminal or civil forensic matters and workers' compensation matters.

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

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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