Neuropsychological Consultants, Inc.

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Consent for Clinical Neuropsychological Evaluation

By signing below I indicate that I agree to undergo a neuropsychological evaluation by members of the staff of **Neuropsychological Consultants, Inc.** This evaluation will involve an interview with me and perhaps others who are familiar with my medical history. Following the interview, my cognitive abilities (e.g., attention, language, memory, motor abilities) and my emotional status will be assessed. The purpose of this evaluation is to show the type and severity of the cognitive and emotional difficulties I may or may not be experiencing.

I understand that neuropsychological assessment is beneficial to me (as well as the referring professional) in understanding the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

I understand that the staff of **Neuropsychological Consultants, Inc.** will send a written report of the findings to the medical professional who referred me for this evaluation and a copy will be sent to me. **Neuropsychological Consultants, Inc.** will keep a record of the details of the interview, the neuropsychological test data, and the final report in a locked filing cabinet and will maintain a secure electronic copy. **Neuropsychological Consultants, Inc.** will not release any portion of your file to anyone other than you, except with your written agreement or if we are ordered to do so by a court of law.

Limits on Confidentiality: I understand that if I say anything about child abuse or elder abuse, the staff of **Neuropsychological Consultants, Inc.** is required by law to report that information to legal authorities. If I talk about plans to hurt myself or commit suicide, or of a plan to harm or kill someone

else, that information must also be reported. In addition, once your report is sent to the medical professionals of your choosing, associates of that medical professional might review that information.

The staff of **Neuropsychological Consultants, Inc**. may use the information we collect from you today for neuropsychological research and/or for teaching purposes. However, your name and any identifying information are never disclosed during these activities, nor is that information available to anyone outside the staff of **Neuropsychological Consultants, Inc**.

I understand that I may withdraw my consent at any time during this examination, and if I choose to do so, the evaluation will be stopped. However, **Neuropsychological Consultants, Inc.** will keep all interview and test data completed before consent was revoked. No report will be written and no information about this evaluation will be sent to anyone without my consent. You should understand that if you have reported child or elder abuse or plans to hurt yourself or another, we remain legally obligated to report this information.

I understand that this consent to treat will expire 12 months from the date of signature.

Patient's Name (Print)	Signature	Date
Guardian/responsible person	Signature	Date
Witness	Signature	Date