



Neuropsychology

5930 E Pima Street Suite 138, Tucson AZ 85712 . phone 520-441-4006 . fax 855-249-5320

Neuropsychological Evaluation Informed Consent

Name of Patient: _____

Patient DOB: _____

Referral Source: The above named patient has been referred for a neuropsychological assessment by (circle all that apply, and specify if appropriate):

Self/Parent Medical Provider: _____

Attorney: _____ Worker's Compensation Contact: _____

Nature and Purpose of Assessment: The purpose of a neuropsychological assessment is to determine a patient's *current* level of neurocognitive functioning. Assessment may include determination of functioning in relation to established developmental milestones/trajectories or determination of *changes* to cognition in the aftermath of a confirmed or suspected neurological insult (e.g., after a traumatic brain injury). Typically assessed neurocognitive functions include relevant aspects of intellectual functioning, attention, memory, language, problem-solving and other executive functions. Screening of fine motor functioning, social skills, mood and personality may also be included. Assessment findings will elucidate relative strengths and weaknesses in a patient's cognitive profile and may point to specific intervention/rehabilitation strategies. In addition to a clinical interview where information regarding a patient's background and current symptoms will be collected, the patient will participate in standardized testing procedures utilizing various protocols. The assessment procedure may include but is not necessarily limited to observing the patient in a learning setting, asking questions about a patient's knowledge of certain topics, asking a patient to read, draw figures and shapes, listen to material presented in an auditory format, view printed material and manipulate objects.

Foreseeable Risks, Discomforts, and Benefits: Assessments can contribute to fatigue, frustration and/or anxiety in some patients. Sessions may be spread across multiple dates accordingly, to minimize the likelihood of these discomforts. Regular breaks will be offered, and assessments can be discontinued at any time at the request of the patient, his/her parent/guardian, and/or the evaluator.

Fees and Time Commitment: By signing this form, you are attesting that you have been provided specific information relating to the fees for this service. You are also acknowledging that you are ultimately responsible for any and all fees not covered by the fee arrangement, by pre-payment or by insurance. Assessments generally require an hour or more of diagnostic interviewing time, several hours of face-to-face testing, and several additional hours of scoring, interpretation and report preparation. An hour-long summary feedback session with the evaluator is also offered.

Limits of Confidentiality: Information obtained during assessments is confidential, and can generally be released only with your written permission. **If the listed patient was referred by an existing medical treatment provider, your signature on this form indicates your permission for the summative evaluative report to be released directly to this provider in order to facilitate continuity of care.** The report will not be released to another party without your written permission, except in the case of special circumstances as delineated below. **If the listed patient was referred by an attorney or by a worker’s compensation representative, that referral source is the official custodian of record. A report will be released directly to the attorney or to the designated worker’s compensation contact, and can be made available to you or other sources only through their written permission or in the case of special circumstances as delineated below.** If this was a self-referral, the report will be released only to you, with further release limited to cases of your written permission except in the case of special circumstances as delineated below.

There are some special circumstances that can limit confidentiality. When present, these circumstances render the evaluator *legally required* to release information that would otherwise be considered confidential. These circumstances include: (a) given a statement of intent to harm self or others, (b) given statements suggesting ongoing harm or abuse of children or vulnerable adults, and/or (c) given legal requests for records or information release either through subpoena (where release may be more limited in scope) or court order (where all information is generally vulnerable for release) as issued formally by a court of law.

Statement Regarding the Voluntary Nature of the Present Assessment: Your or your child’s participation in this evaluation is completely voluntary. The evaluation will not be completed without your signature on this document, and you have the right to stop the evaluation at any time. You also have the right to decline to answer specific questions asked by this writer during the evaluation, though depending on the purpose of the evaluation the evaluator may indicate in the evaluative report those questions you declined to answer.

I have read and agree with each of the points listed above. I have also been given the opportunity to ask any questions I have, and to discuss points of concern directly with the evaluator before signing.

Patient Signature

Date

Parent/Guardian or Authorized Surrogate Signature

Date

Printed Name of Person Providing Consent

Relationship to Patient

Witness Signature

Date