INFORMED CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

You, your child, or the individual you legally represent (_____), herein referred to as "you", have/has been referred for neuropsychological assessment. Please read this document carefully and let us know if you have any questions.

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to gain a better understanding of your cognitive and behavioral functioning and to answer specific referral questions which will be discussed at the start of the evaluation. The primary purpose of this evaluation is to provide information to assist with clinical diagnosis and/or treatment recommendations. This evaluation does not establish an ongoing treatment relationship.

This neuropsychological evaluation will include an interview, during which you will be asked questions about your background, including medical and psychiatric history, and current symptoms. During this evaluation, different techniques and standardized tests will be used including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, listening to recordings, and viewing printed material. You will also be asked information about behavioral, personality/psychological, and emotional factors.

All procedures administered during this evaluation are important, even if the purpose of each procedure is not always obvious. Assessment of effort and motivation is a standard aspect of neuropsychological evaluation. You agree to participate to the best of your ability and to be truthful in your answers. Your participation in this evaluation is voluntary and you are free to refuse to answer any question you choose or terminate the evaluation whenever you wish.

A written report that explains the test findings, diagnostic considerations, and recommendations will be completed after the evaluation is complete. You and your referring doctor will be provided with a copy of the final report. You are welcome and encouraged to attend a feedback session to discuss the results of the evaluation with the neuropsychologist.

Easterseals providers will do their best to address the referral questions and make appropriate recommendations based on test findings. There are no guarantees about results of the evaluation, specific diagnoses, and/or recommendations that might be provided.

Foreseeable Risks, Discomforts, and Benefits: For some individuals, this evaluation can cause fatigue, frustration, and anxiousness. Some questions may touch on personal matters that could cause emotional discomfort. There is no intention of causing personal discomfort, but this is a potential unforeseeable risk associated with this evaluation. Potential benefits in undergoing this evaluation include clarification around diagnosis and treatment, improved self-knowledge and awareness, and identification of appropriate and relevant treatment interventions and supports.

Fees and Time Commitment: This evaluation is estimated to take approximately three to seven hours of face-to-face testing time, in addition to face-to-face time for the initial intake interview. The doctor will also require several additional hours after testing for scoring, interpretation, and report preparation. Though the fees are generally covered by insurance, you will be responsible for any and all fees for the assessment in the event that your insurance company does not pay for services completed. A more complete description of your financial and legal responsibility is described in the Service and Fee Agreement.

Limits of Confidentiality: Information obtained during this assessment is confidential and can ordinarily only be released with your written permission. There are special circumstances in which Easterseals must comply with legal and ethical standards and disclose confidential information related to this assessment without your specific authorization. These special circumstances include a) if there is reasonable belief that you may harm yourself or others, b) when there is reasonable suspicion of harm, abuse, or neglect of children or vulnerable adults, and c) certain court orders, including subpoenas. A more complete description regarding privacy of health information is described in the Confidentiality, Privacy, and Protected Health Information Agreement.

By signing below, I (or my legal designee) acknowledge:

- I have read, understand, and agree with the points listed above.
- I have had an opportunity to ask questions and discuss any concerns before signing this document and these have been addressed to my satisfaction.
- I voluntarily consent to the described services and limitations of confidentiality.

_____	_____	_____
Patient Signature	Patient Name (PRINT)	Date
_____	_____	_____
Legal Representative Signature* *(if applicable)*	Legal Representative Name (PRINT)	Date

_____

*Relationship to Patient (parent, legal guardian/conservator, etc.)

_____	_____	_____
Witness Signature	Witness Name PRINT	Date