RICHMOND NEUROPSYCHOLOGY
Leslie Greenberg, Ph.D.
804.833.3567 Phone

INFORMED CONSENTS and ACKNOWLEDGEMENT of HIPAA NOTICE

Name: ____

I am the (circle one) **Patient** **or** **Parent/Legal Guardian of** ______________________________

Address: ______________________________________ **Phone:** ________________

Email: ______________________________________ **Date of Birth (Patient):** ________

INFORMED CONSENT for ADULT PATIENT

My signature indicates that I have read the office policies of Richmond Neuropsychology and agree to abide by them.

Signature (Adult) __________________________________ **Date** ________

INFORMED CONSENT for MINOR PATIENT (17 years & younger)

My signature shows that I have read or discussed office policies with Dr. Greenberg. (Not needed for very young children.)

Signature (Minor) __________________________________ **Date** ________

INFORMED CONSENT for PARENT/GUARDIAN of MINOR PATIENT

My signature indicates my agreement to respect my child's privacy. (Please both sign if two parents/guardians.)

- I will refrain from requesting detailed information about individual therapy sessions with my child.
- I understand that I will get periodic updates about progress and may be asked to participate in therapy.
- I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality is up to Dr. Greenberg's professional judgment, unless reporting is mandated by law.

Signature of Parent/Guardian of Minor ______________________ **Date** ________
Signature of Parent/Guardian of Minor ______________________ **Date** ________

ACKNOWLEDGEMENT of HIPAA PRIVACY NOTICE

My signature acknowledges that I have read and been given the opportunity to receive a written copy of the HIPAA Notice of Privacy Practices. The current HIPAA Notice of Privacy Practices is posted on RichmondNeuropsychology.com.

Signature (Adult) __________________________________ **Date** ________
Signature (Minor) __________________________________ **Date** ________
Signature (Parent/Guardian of Minor) ______________________ **Date** ________

INFORMED CONSENT for ELECTRONIC COMMUNICATION

I agree to receive and send text messages to Dr. Greenberg for administrative matters only. ___ Yes ___ No

My signature attests that there are risks to electronic communication and a potential risk of exposure.

Signature (Adult) __________________________________ **Date** ________
Signature (Minor) __________________________________ **Date** ________
Signature of Parent/Guardian of a Minor ______________________ **Date** ________

INFORMED CONSENT for TELEHEALTH

My signature indicates I agree to participate in telehealth and understand the benefits and risks.

Signature (Adult) __________________________________ **Date** ________
Signature (Minor) __________________________________ **Date** ________
Signature of Parent/Guardian of a Minor ______________________ **Date** ________

INFORMED CONSENT for COVID PRECAUTIONS

My signature indicates I understand my risk of exposure to COVID and will follow safety protocols, including wearing a mask.

Signature (Adult) __________________________________ **Date** ________
Signature (Minor) __________________________________ **Date** ________
Signature of Parent/Guardian of a Minor ______________________ **Date** ________

CONFIDENTIAL