**NEUROPSYCHOLOGICAL TESTING INFORMED CONSENT**

**Referral Source:** You have been referred for neuropsychological assessment by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Nature and Purpose of Assessment:** The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other brain functions. A neuropsychological assessment may point to changes which can help identify diagnoses and possible compensatory methods and/or treatments. In addition to an interview in which we will be asking you (and possibly a family member/caregiver/friend) questions about your background and current medical symptoms we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, and viewing printed material. All information gathered via interview (with patient and/or family/caregiver/friend), medical records review, and neuropsychological assessment will be included in a report to your referring provider. This evaluation will assist your provider by offering information that may help in diagnosis and treatment planning.

**Foreseeable Risks, Discomforts, and Benefits:** For some individuals neuropsychological assessment can cause fatigue, frustration, and anxiety. Bearing in mind that everyone has different strengths and weaknesses can alleviate some of this discomfort. We ask only that you provide your best effort on all tasks. You will be provided with breaks as needed, and we will attempt to answer all questions to maximize comfort with the testing situation. If necessary, you may terminate the evaluation whenever you wish.

**Fees and Time Commitment:** This assessment generally takes several hours or more. Your insurance company will be billed for this evaluation but it is your responsibility to ensure that this is a covered service under your insurance plan. Any fees not covered by insurance will be the responsibility of the patient. Fees not paid to Sonoran Neuropsychology PLLC can result in use of a collection agency. Should you feel you have received a bill in error, please contact 623-322-4094.

**Limits of Confidentiality:** Information obtained during assessments will be compiled into a report and released to your referring provider. If the fee for this evaluation is being paid by an insurance company or other agency, it may be necessary to share the report to secure reimbursement. Otherwise, information gathered is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicated harm or abuse of children or vulnerable adults; and c) issuance of subpoena from a court of law.

As is your right under HIPAA, you can request a copy of your medical records or to have records released to another medical provider. You will be asked to sign a release of information to process records requests.

If applicable and interested, I give my permission to be contacted regarding future research studies and programs.

YES\_\_\_ NO\_\_\_

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

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Patient Signature Date

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Signature – Witness to consent process Date