CONSENT FOR NEUROPSYCHOLOGICAL SERVICES

Mountainview Clinical Psychology, PLLC
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This consent form is to request the voluntary evaluation of:

_____ by Mountainview Clinical Psychology, PLLC.

Referral Source: You have been referred for a neuropsychological evaluation (i.e., evaluation

of your thinking abilities) by _____.

Nature and Purpose of Evaluation:

A neuropsychological evaluation consists of review of records, interview, and cognitive and psychological testing. I understand that the purpose of this evaluation is to provide information about me for the purposes of diagnosis and treatment planning/recommendations.

The goal of this neuropsychological evaluation is to help you, your treating providers, family, and qualified third parties gain a better understanding of your cognitive strengths and weaknesses and/or determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions as well as emotional and behavioral functioning.

Evaluation is helpful in identifying specific diagnostic considerations and treatment recommendations. Neuropsychological tests are designed to evaluate brain-behavior relationships and help to determine if any changes have occurred in your attention, memory, language, problem solving, visual-spatial abilities, or other cognitive functions. A neuropsychological evaluation may point to changes in brain function and suggest possible methods and treatments.

Evaluation Process: In addition to an interview in which I will be asking you questions about your background and current medical symptoms, I 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, viewing printed material, and manipulating objects. True-false and self-report emotion and personality questionnaires may also be included. Supplementary records from hospitals, treating physicians, professional providers, schools, as well as interviews with designated family, care providers, and individuals who know you well may be included with your consent.

The interview typically takes 45 minutes. Depending on the referral questions, testing can range from as little as 1.5 hours to as much as 4 hours. You will be given breaks as needed and requested. Once the tests are administered, the data analyzed, and relevant records

reviewed, you will be provided with feedback to discuss the results and recommendations. Afterwards, the results will be incorporated into a written report that explains the test findings, diagnostic considerations, and recommendations.

Postdoctoral Fellows: I understand that Dr. Amber Mahan, is a licensed psychologist in the state of Arizona and a Postdoctoral Fellow under the supervision of licensed psychologist, Dr. Kristi Husk. I understand that Dr. Judit Brisette is a Postdoctoral Fellow under the supervision of licensed psychologist, Dr. Kristi Husk. I understand that Kyle Wilson, M.A., is a Psychology Doctoral Practicum Trainee under the supervision of licensed psychologist, Dr. Kristi Husk at Mountainview Clinical Psychology.

By signing this form, I am agreeing to allow the Postdoctoral Fellow, students, and/or psychometricians to administer assessment measures under the supervision of Dr. Husk. Dr. Mahan, Dr. Brissette, and Mr. Wilson may also be involved in providing feedback of your test results and recommendations.

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness about performance. Benefits associated with this assessment include gaining a better understanding of your current strengths and weaknesses, developing a plan to use your strengths to work with or accommodate your weaknesses, and identifying treatment that is specific to your needs. We can take steps to ensure your comfort, such as discussing the procedures ahead of time so you know what to expect, and taking frequent breaks.

Fees and Time Commitment: A typical evaluation includes the time spent directly with you and others who are interviewed. It also includes additional hours for reviewing records, scoring and interpreting the tests, providing feedback, and report preparation. This comprehensive evaluation process is estimated to take 6-8 hours of time.

Payment and Assignment of Benefits: Though the fees are generally covered by insurance, patients are responsible for any and all fees for the evaluation not covered by insurance, including but not limited to deductibles, coinsurance and copays.

Confidentiality: The records concerning this evaluation will be retained by Mountainview Clinical Psychology, PLLC and will be kept confidential. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of a medical emergency, to secure payment for treatment from health insurance plan or other third party payment system, or as permitted by law.

Under the following circumstances, the law requires or permits that information be disclosed: 1. When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse. 2. When a person presents an imminent or potentially serious danger to self or others. 3. In the event of certain court orders, including subpoenas for judicial arbitration or mediation. Release of Information: By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party. In order to release information to individuals other than the referring party, you must sign a

separate written consent form authorizing the release of the requested material to the designated party.

By signing below, I am authorizing payment of benefits to Mountainview Clinical Psychology, PLLC payment of services is thereby directed to them. Mountainview Clinical Psychology, PLLC may need to send information to the insurer to obtain payment for this evaluation.
By signing this form, I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the described services and limitations of confidentiality.

Signature_____Date_____

Printed Name_____

Please read and initial the following disclaimers to acknowledge your understanding :

_____ I understand that this is a clinical evaluation. The purpose is to evaluate my cognition for medical reasons. It is not intended or sufficient to support litigation.

_____ I understand that if I have ongoing litigation and/or have legal representation related to a connected personal injury, we can't see you for a clinical evaluation. I confirm that I don't have such litigation or legal representation.

_____ I understand that it is important that I put forth my best effort. If I don't it will be detected in the data and the results will be invalid.

_____ I understand that completion of the report summary will take two weeks, so I should schedule any follow up appointments with my neurologist or other doctors to review these results at least two weeks after my appointment.

_____ I understand that anything I share with the doctor may be included in the report summary.

_____ I understand that Mountainview Clinical Psychology, PLLC does not determine disability or work status, or complete forms, but will share my test results upon my request with the entities who make these decisions.

Signature_____Date_____

Printed Name_____