Coastal Bend Neuropsychology, PLLC
4646 Corona Drive, Suite 258
Corpus Christi, Texas 78411

Name of Examinee:_____
Date: _____
Time: _____AM/PM

CLINICAL CARE: During evaluation at Coastal Bend Neuropsychology, PLLC, the patient will at all times be under the professional care of a clinical psychologist or clinical neuropsychologist. The clinical psychologist or clinical neuropsychologist is assigned by the Clinic or determined by the referring individual (e.g., physician). The undersigned understands that no guarantees have been made as a result of examination of the patient in the Clinic.

CONSENT FOR EVALUATION: The undersigned voluntarily consents to the patients' receipt of the usual Clinic services.

COMPLIANCE WITH RULES AND REGULATIONS: In consideration of registration and/or treatment, the patient agrees to abide by the rules of the Clinic.

DISCLOSURE OF INFORMATION: The undersigned agrees that all records concerning this examinee's assessment shall remain the property of the Clinic. The undersigned understands that medical records and billing information generated or maintained by the Clinic are accessible to Clinic personnel. Clinic personnel may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this patient. The Clinic is authorized to disclose all or part of the examinee's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of examinee's account. THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

RELEASE FROM RESPONSIBILITY: The undersigned hereby agrees, acknowledges and understands that the Clinic is not responsible for injuries sustained by use of a patient’s own personal equipment: electrical, mechanical or otherwise. It is further understood that, should the patient leave the Clinic without the consent of the clinical psychologist or clinical neuropsychologist, the undersigned hereby relieves said professional and Clinic of all responsibility for such action.

PAYMENT RESPONSIBILITY: The undersigned understands that the examinee, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Clinic relating to services rendered by the Clinic to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party.

ASSIGNMENT OF BENEFITS: The examinee hereby makes the assignment of benefits as set forth below:

INSURANCE: The examinee hereby assigns to Coastal Bend Neuropsychology, PLLC, all benefits under any insurance policy, health plan, worker's compensation or other third party payor liable to the patient, in consideration for services rendered by the Clinic.

PRACTITIONERS: I also assign benefits to all practitioners involved in the care of this period of illness, evaluation, or treatment.

PARTICIPATION IN THE EVALUATION: Your participation in this evaluation is voluntary (unless you have been ordered by the Court to be evaluated). We will not complete the evaluation without your signature on this document. You have the right to terminate the evaluation at any time. Of course, there may be consequences related to any ongoing cases an insurance company or court if you elect to terminate the evaluation prematurely. If, at any time, you have a question about any aspect of the evaluation or these procedures, please feel free to ask us. Once the evaluation is completed, at the provider's discretion, we may be able to complete a feedback session with you, in which we would discuss and explain the results of the evaluation and answer any questions you might have, and provide you with a copy of your evaluation report.

CERTIFICATION: THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE EXAMINEE, OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE EXAMINEE UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND ACCEPT ITS TERMS.

_____Date: _____ Time: _____
Signature of Examinee

_____
Clinic Witness to Signature

WHEN EXAMINEE IS A MINOR OR INCOMPETENT TO GIVE CONSENT: I hereby consent for the examinee.

_____Date: _____ Time: _____
Signature of Person Authorized to Consent for Examinee

_____ _____
Relationship to Examinee Clinic Witness to Signature