THE CLINIC
NEUROPSYCHOLOGICAL & PSYCHOLOGICAL SERVICES

INFORMED CONSENT FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL EVALUATION, AND/OR TREATMENT

Patient Name _____ Date of Birth _____

Consent for Evaluation and Treatment

I give permission to *The Clinic Neuropsychological and Psychological Services, PLLC* (hereafter referred to as *The Clinic*) and its agents or employees to provide clinical services as needed.

I have discussed all of the relevant reasons for requesting the evaluation and/or treatment and understand the services that will be provided. I understand that, for valid test results, I must provide my best effort, which will also be assessed. Initials_____

I understand that _____ is an assistant and is working under the supervision of Dr. Wayne Dees, a licensed clinical neuropsychologist. Initials_____

I give permission to audio record portions of the examination for scoring accuracy. Initials_____

I consent to the confidential use of my evaluation for research for professional and scientific purposes as long as information is not associated with any of my personally identifying information. Initials_____

Consent for Release of Confidential Information

I understand that my referring physician will receive the final report. I authorize *The Clinic* and its agents or employees to receive information from and disclose information to:

Name & Contact Info: _____

_____

Name & Contact Info: _____

_____

Name & Contact Info: _____

_____

The following information: clinical records and/or information necessary for the filing of insurance claims. I understand that I am protected by Federal Law from the secondary release of medical/mental health information by the insurance carrier. Initials _____

Limits of Confidentiality

I have been informed and understand that information conveyed to my *The Clinic* doctor(s), its agents or employees is confidential except in the following situations according to Texas State Law:

A. If I communicate to *The Clinic's* doctors, agents, or employees that a serious threat to harm an identifiable person is intended, the identified person and the police must be warned;

B. If *The Clinic's* doctors, agents, or employees suspect child abuse or neglect, or abuse of a helpless adult or elder, a report must be made to the appropriate agency;

C. and if I appear to be in danger to myself or others, hospitalization may be necessary. Initials_____

Litigation and Confidential Information

I understand that:

A. Information and records, otherwise confidential, or testimony concerning my treatment/ assessment must be provided in the event of a court order;

B. In litigation or official proceedings, information and records, otherwise confidential or testimony concerning my treatment/assessment, may have to be provided in limited circumstances without my specific consent, in accordance with applicable law. Initials_____

Signature: _____ Date: _____