Lifespan Neuropsychological Services

(An independent contractor of Collaborative Counseling)
403 Stageline Road, Hudson, WI 54016
Phone: (763) 210-9966 or (715) 808-8969
Fax: (763) 210-6886

Informed Consent for Psychological/Neuropsychological Evaluation

This document represents a summary of major issues discussed during the informed consent process prior to neuropsychological evaluation and reviewed at greater length in the **Clinic Information and Client Consent Policies for Collaborative Counseling and Lifespan Neuropsychological Services** (i.e., Collaborative Policies). "I", as used in this consent, may refer to you directly or to a minor child for whom you are the legal guardian.

Purpose of Evaluation/Benefits and Risks: I understand that I have been referred for a psychological/neuropsychological evaluation. The purpose of this evaluation is to provide information about my current cognitive and emotional status to me and my physician(s) and/or other health care provider(s) to assist with diagnosis and treatment planning.

Potential benefits of the evaluation include assistance in making an accurate diagnosis and in decision-making regarding treatment and other management issues. Potential risks are generally minor and include the possibility that neuropsychological testing procedures may be difficult and cause frustration and/or fatigue and that some of the information discussed in the clinical interview may include personal information and/or involve emotional discomfort.

Nature of the Evaluation: If the neuropsychologist determines that psychological evaluation is sufficient to address symptoms/concerns resulting in my referral for psychological/neuropsychological evaluation, the evaluation will generally include a clinical interview, completion of questionnaires, and/or brief cognitive screening measures. If a neuropsychological evaluation is deemed essential, the evaluation will include a detailed interview, tests of my thinking abilities (e.g., memory, attention, problem-solving skills), and measures of mood/personality. The testing strategy will be developed and tests administered by the licensed clinical neuropsychologist on the basis of her clinical expertise, knowledge of research findings about brain function, and current standards of practice in clinical neuropsychology.

Test performance and responses to questionnaires designed to address adaptive/emotional function can be influenced by many factors, including variable motivation. However, consistent effort and active participation in evaluation procedures are crucial to ensure that test results accurately reflect emotional status and brain function. Given the importance of accurate diagnosis, techniques designed to detect the possibility that test performance may be negatively impacted by non-test factors (e.g., poor effort, exaggeration of symptoms) may be included in the evaluation.

Confidentiality: The information generated on the basis of this evaluation will be used to prepare a report. This report is considered a confidential medical record and generally will be distributed as follows: (1) to you during an informational meeting with the neuropsychologist following your neuropsychological assessment, (2) placed in your electronic medical record maintained by Collaborative Counseling, LLC, and (3) to the physician, therapist, or agency who referred you for neuropsychological evaluation based on your signed HIPAA compliant release of information form, as well as to other providers involved in your care only if you express a wish to share the report with these providers. However, it will be important for you to review other conditions under which your medical records may be released based on HIPAA or state of Wisconsin rules regarding release of protected health information. These conditions generally involve potential harm to you or others based on disclosures or assessment results indicating significant risk, abuse of a minor/vulnerable adult, business operations ancillary to your assessment/treatment, or state/federal laws regulating release (e.g., Workman's Compensation actions, court orders). A detailed description of these conditions is provided in Clinic Information and Client Consent Policies for Collaborative Counseling and Lifespan Neuropsychological Services. Protocols containing test questions/instructions are protected by intellectual property law, copyright law, and the ethical code of the American Psychological Association. These protocols will not be released to you and will be released to others only under very specific circumstances.

Findings based on psychological/neuropsychological evaluations are often viewed as helpful in forensic proceedings. However, ethical concerns/operating principles related to forensic evaluations differ from those involved in evaluations done in non-forensic situations and insurance companies generally do not consider these types of evaluation appropriate to meet the demands of medical necessity. Given that this evaluation is not designed for forensic purposes, the neuropsychologist will not be available to discuss this evaluation's findings with an attorney who represents you in any pending or future litigation. Greater detail about release of information to attorneys and responses to subpoenas is contained in Clinic Information and Client Consent Policies for Collaborative Counseling and Lifespan Neuropsychological Services

Communications: I understand that there exist limitations to the security of communications (emails, texts) and immediacy of response to my telephone communications with the neuropsychologist. Given this, I understand that in emergency situations I must seek help via alternative resources (i.e., local hospital emergency room, crisis help line). I also understand that use of email communications for anything other than scheduling issues is discouraged.

Assessment of Children/Adolescents: I understand that the neuropsychologist requires the consent of both parents to proceed with neuropsychological assessment of a minor child and that information obtained during the assessment will be shared with both parents, unless the custodial parent provides a court order limiting access or communication. I also understand that the law provides special protections for minor children and that the neuropsychologist is required by Wisconsin state law to report suspected child abuse or neglect based on information obtained during the neuropsychological evaluation.

Telemedicine: If I am consenting to psychological/neuropsychological assessment services via telemedicine, I understand that there exist privacy and security risks including the possibility of interrupted or distorted transmission of data/ information, access to or interception of protected health information by unauthorized persons, and the possibility that telemedicine services may not be as effective as in-person services. By providing written informed consent for a telemedicine session, I understand that psychological/neuropsychological test content is protected by copyright and intellectual property laws and agree not record in any manner (written, audio, video) test content or instructions conveyed during the test session. I also agree that I will not record interactions with the neuropsychologist during intake interview or test review sessions unless the neuropsychologist and I mutually agree in writing that the session may be recorded.

I also agree to designate an emergency contact person and to provide HIPAA-compliant written informed consent giving the neuropsychologist permission to contact this person if she becomes concerned about my safety.

Charges for Services: Collaborative Counseling and its agents are responsible for billing/collections, in a manner consistent with policies you have consented to during review of Collaborative Counseling billing policies, reviewed as part of this informed consent. You will be charged for the clinical interview, test administration, test scoring, data analysis/report writing, and the information session designed to review test findings at a rate of $225/hour. You will be held responsible for any charges not covered by your health insurance policy, including any co-payments or deductible amounts.

These policies and procedures have been explained to me, I have been provided with a copy of the document entitled "Clinic Information and Client Consent Policies for Collaborative Counseling and Lifespan Neuropsychological Services" and understand that my signature on this abridged document acknowledges an understanding that all information contained in the lengthier document is applicable to my psychological/neuropsychological evaluation. I have been provided the opportunity to ask questions to clarify my understanding of the clinic policies of Lifespan Neuropsychological Services, LLC and Collaborative Counseling, LLC. Given knowledge of these policies and procedures, I agree to undergo psychological or neuropsychological evaluation.

Date: _____

Client or Guardian Signature: _____

Client Name (printed): _____

Collaborative Counseling Client Information

Client Name: _____ **Date of Birth:** _____

Address:

Street	City	State	Zip Code

Parent(s) Names/Addresses if client is a minor:

Name	Street Address	City/State	Zip Code

If client is a minor, check below to indicate custody status:

☐ Parents are married to each other and both are legal parents of the child/minor.

☐ I am a single parent with legal and physical custody of the child/minor.

☐ The child's other parent and I share legal custody. Consent must be obtained from the other parent to continue services beyond the initial appointment.

☐ The child is in the custody of _____ County in the state of Minnesota or Wisconsin.

Phone (Adult client or guardian of child)**:**

Home	Work	Cell

Do you consent for the use of your email by Collaborative Counseling/Lifespan Neuropsychological Services? _____

Email Address: _____

Employer: (If intake is for a child write employment for both parents)

Name	Street Address	City	Zip Code

Insurance Information:

Primary Insurance Information:

Insurance Company	Policy Number	Group Number
Policy Holder Name	**Policy Holder Date of Birth**	**Insurance Company Customer Service Number**

Secondary Insurance (If applicable):

Insurance Company	Policy Number	Group Number
Policy Holder Name	**Policy Holder Date of Birth**	**Insurance Company Customer Service Number**

Client Billing Policies:

Our billing policy for services, which are the client's responsibility, are as follows. Please enter your initials into the "Click or tap here to enter text" region to indicate that you have reviewed and agree to each of these policies.

_____ All co-pay, co-insurance, sliding fee scale, payment plan, and deductible amounts are due on the date of service. If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, charges will be submitted to the client credit or debit card on file in our office.

_____ Clients will not receive a statement for services that are the responsibility of their insurance company. Nor will clients receive a statement if their balance has been paid in full on each date of service and their account is current.

_____ Any counseling services that are not eligible for coverage through a client's insurance plan become the responsibility of the client. If not paid on the date of service, these charges will be submitted to the credit card on file either on the date of service, or on the date we receive notice that services have been denied. Receipts for all credit or debit card transactions will be mailed to clients, along with their statement. Payments due that are not paid are subject to fees within the limitations of the law.

_____ A late client fee will be submitted to the credit or debit card on file for clients with private insurance coverage, a payment plan, or a sliding fee scale which includes cash clients. This charge is submitted on the date of service only if clients miss an appointment without giving a 24 hour notice to cancel or do not show up to a scheduled appointment without notice.

_____ By signing: (1) I understand that if I default on any payment obligations, as called for in this agreement, Collaborative Counseling, LLC will have the right to forward my information to collections and in the event that it becomes necessary to utilize a collection agency to resolve a past due account up to an additional 30% will be assessed to my account to cover the costs of this action. (2) I agree to pay all costs of collection, including but not limited to collection agency fees, court costs, and attorney fees., and (3) I understand and give my consent for Collaborative Counseling, LLC, to forward my information to collections should I default on this agreement and fail to pay my Balance Due.

Policy/Billing Informed Consent:

Collaborative Counseling, LLC, reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to assessment/treatment at Collaborative Counseling, LLC, and have received and understand the contents of the clinic's assessment/counseling policies, including the Notice of Privacy Practices (HIPAA). My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Collaborative Counseling, LLC to pursue any outstanding balance due to them should I not follow the clinic policy. I am of sound mind and am fully competent to give informed and willing consent for assessment or therapy, either for myself and/or a minor child. If I have questions, the information has been explained and/or summarized for me.

_____ Date: _____

Signature (client or legal guardian if client is under 18)

_____ Date: _____

Signature (client or legal guardian if client is under 18)

Credit Card Information: We require that all clients keep a credit/debit card on file in accordance with the above billing policy.

Name on Credit/Debit Card: _____ Billing Zip Code: _____

Card Type: _____ Card Number: _____

3 Digit Security Code: _____ Expiration Date: _____

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Collaborative counseling, LLC may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Collaborative Counseling, LLC to utilize my credit card information for any outstanding balance.

_____ Date: _____

Signature of Credit Card Holder Authorizing Payment

Initials of Witness: _____