Tarazi Neuropsychology Services LLC
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CONSENT FOR EVALUATION/CONSULTATION

Patient's Name: _____
Date of Birth: _____

I,_____ give consent for the above named patient and/or myself to receive services at Tarazi Neuropsychology Services LLC, until I notify Tarazi Neuropsychology Services LLC otherwise or until Tarazi Neuropsychology Services LLC determines that services are no longer appropriate or will not be provided. In the case of a minor, I certify that I have the legal authority to authorize and consent to treatments and evaluations as parent, guardian, or managing conservator.

Purpose and Procedures:

The purpose of the evaluation or consultation is to better understand various aspects of your/your child's cognitive, learning, social-emotional, and/or behavioral functioning. This helps in diagnosing any cognitive, learning, or developmental conditions, understanding strengths and weaknesses, and guiding treatment or recommendations.

The consultation/evaluation may include an interview, review of previous reports/records, completion of questionnaires, standardized testing and data collection, and/or school observation. Testing may be completed in one session, or over several sessions and days, and the length of testing is determined by the kind of evaluation needed. A separate appointment is typically scheduled to discuss the results of the evaluation. I may have the option for some appointments to be conducted by telehealth.

Confidentiality:

I understand that any information I provide to Tarazi Neuropsychology Services LLC is confidential and generally will not be released to others without my written consent. I understand that a copy of the final report will be shared with me as well as those to whom I give permission for the report to be sent. Records requested by other parties will require me to sign a release form.

I understand that state and/or federal law might require disclosure of my/my child's confidential information without my consent in one or more of the following situations (but not limited to the following): If a child is the suspected victim of abuse or neglect; if the patient is believed to be a danger to self or others; if information is disclosed about the physical or sexual abuse of a minor, person who is disabled, or an elder person; if a suit is filed by me against Tarazi Neuropsychology Services LLC; or if a court order, legal proceeding, statue, or regulation requires disclosure.

Voluntary Participation:

Participation in this neuropsychological evaluation, whether in-person or via telehealth, is voluntary. I may discontinue the evaluation at any time, and this will not affect my right to receive care from my healthcare providers. I understand that an incomplete evaluation may affect the clinician's ability to form conclusions and offer complete recommendations.

Payment:

I understand that Tarazi Neuropsychology Services LLC does not accept insurance and that I am responsible for the cost of the consultation/evaluation as agreed upon prior to the first visit. I understand that payment for services is due before or at the beginning of the appointment, unless other arrangements are made prior to the appointment. I understand that I can request a summary of procedure codes and diagnoses to submit to my insurance company, but there is no guarantee that these activities are reimbursable. I understand that I will be charged $300 if I/my child does not show up for a testing session without contacting Tarazi Neuropsychology Services LLC to cancel at least 24 hours in advance. I understand that I will not receive a written report until my balance for services is paid in full. I understand that if I withdraw my consent for evaluation I will still be responsible for payment for any procedures and office visits that were conducted prior to the withdrawal.

____ (Initials)

Telehealth Consent (if applicable):

Telehealth is the use of technology (such as video conferencing or telephone) to conduct parts of the evaluation remotely. This option may be chosen for clinical interviews/intakes, consultations, and/or feedback but is not required. If I opt for telehealth services, when available, I acknowledge the following:

1. **Technology Requirements:** I will need a stable internet connection, a device with a webcam, microphone, and access to the appropriate telehealth platform.
2. **Confidentiality:** Telehealth services are conducted using secure, encrypted platforms that comply with HIPAA (Health Insurance Portability and Accountability Act) to ensure privacy and confidentiality. However, I acknowledge that no electronic transmission is 100% secure, and there is a small risk of privacy breaches.
3. **Technical Issues:** In the event of a technical failure (e.g., connectivity issues, device malfunction), the evaluation may be paused, rescheduled, or conducted by other means.
4. **Recording:** I understand that I do <u>not</u> have permission to personally video, audio record, or take pictures during any part of this assessment or treatment session whether in person or telehealth.

YES, I agree _____ NO, I do not agree _____

____ (Initials)

Phone Communication:

I agree that appointment and scheduling communication can be communicated via text and/or voicemail messages and acknowledge privacy concerns.

YES, I agree _____ NO, I do not agree _____

Phone number: _____

____ (Initials)

Email Communication:

Because email is not a secure form of communication, Tarazi Neuropsychology Services LLC cannot ensure the confidentiality of email messages. **I agree to receive an electronic copy of the final report at the email below.** I acknowledge that email communication is not considered a secure form of communication and the confidentiality of such communication cannot be guaranteed.

YES, I agree _____ NO, I do not agree _____

Caregiver email: _____

____ (Initials)

Acknowledgment and Consent:

By signing this consent form, I acknowledge that I understand and agree to the conditions outlined above and that I have had the opportunity to ask questions and that my questions were answered to my satisfaction.

_____
Signature of Parent/Conservator/Guardian/Legal Representative or Patient (if 18 or older)

_____
Printed Name of Parent/Conservator/Guardian/Legal Representative or Patient (if 18 or older)

_____
Relationship to Patient

_____
Date