Neurobehavior Services, Inc. **Email: Admin@NeurobehaviorServices.com**

Janiece Turnbull, PhD & Associates
Clinical Neuropsychology, Pediatric & Adult
Consultation, Assessment, & Treatment
www.NeurobehaviorServices.com

685 East California Boulevard
Pasadena, CA 91106
Voicemail: 626.577.7744
Fax: 888.220.2463

CONSENT FOR NEUROPSYCHOLOGICAL ASSESSMENT

(For Minor Child)

YOUR NAME:____ TODAY'S DATE: __________

CHILD'S NAME: _______________________________________ CHILD'S BIRTH DATE: ___________

Please read and initial each item that you agree to:

____ I authorize Dr. Janiece Turnbull to provide assessment for my child for neuropsychological purposes.

____ I provide authorization for Dr. Turnbull to conduct face-to-face testing with my child.

____ I understand that the assessment will cover the following: interviews with parents, child, teacher/s, and other treating professionals (if applicable and authorized); administration of tests; scoring and interpretation of data; the neuropsychological report; verbal feedback with parents; and verbal feedback to the referral source (if appropriate and authorized). Dr. Turnbull schedules one meeting for the initial parent interview and one meeting for the parent feedback session. Parents requesting separate or additional meetings for either appointment will be billed at Dr. Turnbull's rate of $200/hour.

____ I understand that the fee for the assessment of $4500.00 is payable at the parent interview. *Dr. Turnbull does not accept credit card payment.*

____ Dr. Turnbull schedules one client per week, and appointments are often booked months in advance. If you need to cancel your assessment for any reason, we ask that you *please* provide at least a one-week notice so that we are able to accommodate the families on our waiting list.

____ I understand that if I provide notice of cancellation or reschedule fewer than two full business days in advance (48 hours, not including weekends), I will be charged a fee of $400 per testing day and $200 per other in-person appointment.

____ In the event of a cancellation, I understand that I will be responsible to remit payment for the total hours accrued prior to the date of cancellation (for example, for time spent conducting interviews with parents / teachers). An invoice will be emailed at Dr. Turnbull's rate of $200/hour.

____ I understand that all information obtained during the course of this assessment is confidential unless I authorize a release of this information in writing, i.e., a signed release of information.

____ I understand that Dr. Turnbull supervises psychological assistants who are unlicensed and allowed to provide limited services (e.g. attendance and observation at parent interview and feedback session and present at testing sessions with Dr. Turnbull) only under the direct supervision of Dr. Turnbull.

(*continued on the next page*)

____ I understand that Dr. Turnbull's office manager and/or psychological assistant/s have access to confidential files, although *only* as related to their duties. All employees and psychological assistants of Dr. Turnbull have been educated on confidentiality issues and signed a confidentiality agreement as a condition of obtaining/sustaining their position.

____ I understand that when I sign a 'Consent to Obtain Information,' that this allows Dr. Turnbull to *obtain* information relevant to this assessment only. The specific person and information to be obtained will be specified on the consent form.

____ I understand that when I sign a 'Consent to Release Information,' that this allows Dr. Turnbull to *provide* information regarding the results of this assessment. The specific person and information to be released will be specified on the consent form.

____ I agree to allow communications to take place by <u>fax</u> (to those for whom I have provided a signed consent for Dr. Turnbull to obtain or release information).

____ I agree to allow communications to take place by <u>email</u> (to those for whom I have provided a signed consent for Dr. Turnbull to obtain or release information).

____ I agree to allow communications to take place by <u>cell phone</u> (to those for whom I have provided a signed consent for Dr. Turnbull to obtain or release information).

____ I have read and understand the following Limits to Confidentiality:

- If you submit a claim for reimbursement to your insurance company, it will be necessary to provide diagnostic code/s to the insurance company. It may be necessary to send a copy of the final report to that agency to secure reimbursement.
- The written report and any other information discussed in the assessment is confidential, and it will not be shared without written permission except under the following conditions:
  - Threat of suicide
  - Threat of harm to another person(s), including murder, assault, or other physical harm
  - Suspected child abuse, including but not limited to, physical beating and sexual abuse
  - Abuse of the elderly
- Be aware that state law mandates that all mental health professionals may need to report these situations to the appropriate persons or agencies.
- In addition, if the client is involved in a legal action and claims mental health issues related to the legal action, records may be released.

I have read and understood the above. (If shared custody, *both* parents must provide consent.)

____ ______________________________

Signature of Parent / Legal Guardian Date

____ ______________________________

Signature of Parent / Legal Guardian Date