



Beth Cook, Ph.D
Neuropsychologist
(415) 710-6597

Consent for Neuropsychological/Psychodiagnostic Evaluation

This consent form is to request the voluntary evaluation of _____
by Beth Cook, Ph.D.

Evaluation Process: The goal of this evaluation is to help you, your treating providers, and qualified third parties gain a better understanding of your relative strengths and weaknesses, any subtle or remarkable changes relative to premorbid functioning, specific diagnostic considerations, and treatment recommendations. The tests employed are designed to evaluate brain-behavior relationships and include measures of language, attention, memory, abstract reasoning, spatial-perceptual organization, and visuomotor skills. True-false and self-report emotion and personality questionnaires will be included. A comprehensive clinical interview will also be conducted. In addition, supplementary records from hospitals, treating physicians, psychologists, schools, as well as interviews with designated family and/or friends may be reviewed with your consent.

The interview and testing process itself typically lasts approximately 6-8 hours total. You will be given a break for lunch and shorter breaks as necessary. Once the tests are administered, the data analyzed, and relevant records reviewed, the results will be incorporated into a written report that explains the test findings, diagnostic considerations, and recommendations. A post-test consultation will be scheduled in order to discuss the results.

Typical costs. A typical evaluation is comprehensive and includes not only the time spent directly with the client, but also time spent reviewing records, scoring the tests administered, interpreting the results, and writing the report. The direct testing time is approximately 6-8 hours. Reviewing records, scoring tests, interpreting test results, writing the report, and meeting for a feedback session will likely add 6-8 hours to the direct contact time. Additional information on fees is available upon request.

Payment Issues

Assignment of benefits. By signing below, I am authorizing payment of benefits to Dr. Beth Cook; payment for services is thereby directed to her. Dr. Beth Cook may need to send information to the insurer in order to obtain payment for this evaluation.

Confidentiality: The records concerning this evaluation will be retained by Dr. Cook and will be kept confidential according to the California Welfare and Institution Code Section 5328. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of medical emergency, to secure payment for

treatment from health insurance plan or other third part payment system, or as permitted by law. Under the following circumstances, the law requires or permits that information be disclosed:

1. When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse.
2. When a person presents an imminent and/or potentially serious danger to self or others.
3. In the event of certain court orders, including subpoenas for judicial arbitration or mediation.

Release of Information: By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party. In order to release information pertaining to your case to individuals other than the referring party, you must sign a separate written consent form authorizing the release of the requested material to the designated party.

Acknowledgement and Consent:

By signing this form, I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the described services and limitations of confidentiality.

I am welcome and encouraged (but not required) to bring a friend or family member to the feedback session.

Date

Witness