P E S I

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INFORMED CONSENT FOR TESTING

Please read these instructions (or read them to the patient):

The neuropsychologist would like to ask you some questions and request that you complete some papers to see how you are feeling today. While the questions, at times, are personal, your answers will help your doctors understand how your pain or injury has affected your life.

Please answer the questions sincerely and truthfully. You do, however, have the right not to answer any question you do not wish to. The results of your answers will be interpreted by a licensed clinical psychologist, and the resulting report will be provided to your doctor to help plan the treatment for your problems. No one else will see your answers to the questions except the neuropsychologist and the psychologist who writes your evaluation report.

Your task is to answer questions as accurately as you can; for example, when discussing your problems, do not minimize significant problems, but also do not exaggerate lesser concerns. You are to give your best effort during the testing. This does not mean that you have to get every answer or problem correct, for no one ever does. However, you do have to give your best effort. Part of the examination will address the accuracy of your responses, as well as the degree of effort that you exert on the tests.

If you have any questions regarding this evaluation, you can request that the neuropsychologist talk with you about your concerns. If you are in agreement with the conditions outlined, please sign this paper and mark the date of your signature.

I hereby freely give my consent to the administration of a series of psychological tests and/or participate in psychological treatment and evaluation. I understand that these tests are for the purpose of evaluating various psychological functions which might include cognitive functioning, extent of symptoms, as well as emotional adjustment. I understand that these tests are intended to permit conclusions regarding brain functions, personality adjustment, impact of psychological functioning on daily functioning, and other aspects of adjustment.

_____ _____
Examinee Signature Date

_____ _____
Examiner/Witness Date

AUTHORIZATION TO DISCLOSE PROTECTED MENTAL HEALTH INFORMATION

I, _____, hereby give my consent and authorization to the neuropsychologist to obtain and receive privileged information and confidential medical records specified below from any physician, hospital, medical facility or insurance carrier, by electronic copy or facsimile transmission, for the purpose of psychological/neuropsychological evaluation. I understand this may include information concerning communicable diseases, mental illness, chemical or alcohol dependency, laboratory tests results, medical history, treatment, and other such related information. I specifically authorize the neuropsychologist to obtain and receive the results of any prior neuropsychological or psychological evaluations, as well as the associated raw data for those evaluations, for the purposes of this examination and related reporting.

I understand my records may be released to my insurance carrier, my treating or consulting physicians, and to a state- or federal administrative agency as applicable, as allowed by law and for the purpose of treatment. I understand that the neuropsychologist will provide me a copy of this signed authorization form, and if I have questions about redisclosure of my protected health information, I can contact the neuropsychologist or his staff.

I understand this authorization will be valid for a period of 1 year from the date signed unless otherwise specified (_____). I understand that I may revoke this authorization at any time in writing by sending a letter to the neuropsychologist. I understand that revocation will not be effective to the extent that action has already been taken in reliance on it.

I specifically authorize the neuropsychologist to release a copy of my report to the following individual/organization: _____ (phone _____). I understand that if I authorize the disclosure of my health records to someone who is not legally required to keep it private, they may be redisclosed and may no longer be protected.

Patient: _____

SS #: _____

DOB: _____

_____ _____

Examinee or authorized Signature Date

_____ _____

Examiner/Witness (sign and print) Date

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL INDEPENDENT EVALUATION AGREEMENT

Examinee Name: _____ Date: _____

Please read each item carefully, then initial each:

1. I understand my signature to this document provides me notice that the neuropsychologist is evaluating me to assist in a forensic medical or legal matter. My signature on this document indicates that I understand why this evaluation is being done and have agreed to such evaluation. I understand that if I have questions about the nature of this evaluation, I may raise them with the neuropsychologist. I understand this is an independent evaluation and the neuropsychologist has or may be retained as a possible expert witness.
2. I have been advised that as a result of this evaluation, the neuropsychologist will prepare a written report about my present psychological/neuropsychological functioning, relevant medical/psychiatric/psychological history (possibly including AIDS/HIV status and drug use), and offer his professional opinion(s) on my psychological fitness for duty, psychological condition, and/or the neuropsychological functioning including whether or not I may constitute a safety hazard to myself or to others. This information will be shared with whoever is requesting this evaluation and may become part of a public court record. Also, it has been explained to me that the release of the results of my evaluation to another entity, and the evaluation findings (depending on the nature of this assessment) could have an impact on my financial, legal, employment, or other interests. The neuropsychologist is unable to specify the exact nature of those potential consequences.
3. I understand that I do not have to answer any questions which I find too distressing, although he may ask me for my reasons and record those reasons in my report. This might have an adverse impact on my interests in ways neuropsychologist cannot reasonably foresee. The questions asked today may be personal in nature. I may be given one or more formal psychological/neuropsychological tests to help the neuropsychologist form an opinion. These tests may be distressing. My signature to this document provides I have been advised about this possibility. I have been advised to notify the neuropsychologist and/or call my treating Doctor if I become distressed.
4. By signing this document, I understand that the neuropsychologist may have a “duty to warn” if he becomes aware that I intend to inflict serious bodily harm to a specific individual or individuals, and he has a duty to protect the intended target(s), which may include alerting law enforcement officials, and could involve warning the potential victim directly. There may be circumstances in which the neuropsychologist might be required to release information without my consent (a “duty to report”), such as abuse/neglect of children or vulnerable adults, sexual contact between me and a previous mental health professional, court orders, compliance with state/federal laws, rules or regulations, professional disciplinary actions, etc.

5. I understand the neuropsychologist is not providing treatment to me. Instead, the service being provided today is an evaluation for purposes of determining my neuropsychological/psychological condition. The neuropsychologist is not forming a Doctor/Patient relationship. Normally, I would have the opportunity to follow up with the neuropsychologist to discuss the results of my evaluation; however, my signature indicates I have been informed this is a “forensic” evaluation, and I will not have that opportunity. As a result of this, I agree to waive my right to receive a copy of my report directly from the neuropsychologist. The neuropsychologist agrees to, if possible, facilitate the transfer of my report to my treating doctor or an authorized third party if applicable.
6. However, I understand that the nature of this forensic evaluation may limit the right of access to certain oral and written information, records and reports related to me that have been or are being created by the neuropsychologist. I understand that the neuropsychologist may be required, to the extent permitted by applicable law, rule, regulation or order, to refuse any request or demand for access to or copies of any of the information, records and reports relating to me that have been created or obtained by the neuropsychologist, even if the request or demand is made by or on my behalf. The neuropsychologist will abide by any law, rule, regulation or order requiring disclosure of the information, records and reports, notwithstanding that I have waived my right of direct access as noted above.
7. I furthermore understand that I am waiving certain rights under HIPAA and State law regarding confidentiality and the transmission of my records. I understand my report may be provided to lawyers and/or claims representatives and/or plaintiffs as part of a lawsuit. Otherwise, the neuropsychologist agrees to follow all pertinent State and Federal Law to guard the confidentiality of this report. It will not be otherwise released without my and/or the client’s express permission.
8. I have not been “coached” as to how to perform on these tests by my lawyers or any other party and have not discussed these tests or how to perform in such an evaluation with anyone. I have not attempted to learn anything about these tests which would allow me to alter my test results or otherwise invalidate them. I have not accessed the internet to learn about these tests.
9. I have been notified and agree to have parts of my examination audio or videotaped and to have my picture taken if required by the agency or party requesting this evaluation. These may be included in my report. I understand that I may have portions of my examination conducted via telepsychology (see addendum as applicable). However, I may not surreptitiously audiotape or videotape this examination and understand no third party observer may observe this examination.
10. I have been notified that an intern, post-doctoral fellow, or a professional interpreter may also assist in part in administering some of the tests used today. Interns and post-doctoral fellows are those individuals who have earned a Doctoral degree in psychology and are completing a required tenure of one (1) to two (2) years as part of the requirements for state licensure and/or board certification.
11. I understand that the test materials (the actual test forms) produced today can only be released to another psychologist, and that copyright protections and state and federal law do not allow its general release. However, a copy of the final narrative report generated from this evaluation will be provided to my attorney or doctor if requested, and that a data table of scores can be provided on request.

12. Risks Associated with This Evaluation: There are no known physical risks. Generally, psychological and/or emotional risks are minimal and consist of possible temporary emotional discomfort (such as frustration or anxiety while working on more challenging measures), and fatigue. A small number of individuals could experience greater emotional distress from becoming aware of limitations or areas of difficulty that may have been previously unknown to them, or from having to discuss difficult issues with the examiner.
13. I understand that the neuropsychologist cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form.
14. A facsimile of this document shall be considered as valid as the original. I understand that the neuropsychologist will provide me a copy of this signed authorization form on request.

_____ _____

Examinee Signature Date

_____ _____

Examiner/Witness Date

TELEPSYCHOLOGY ADDENDUM:

I understand that I may engage in telepsychology with neuropsychologist as part of my evaluation. I understand that "telepsychology" refers to providing psychological and neuropsychological services using telecommunications technologies, such as video conferencing. I understand that telepsychology involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Texas or outside of Texas. I understand that by agreeing to engage in telepsychology services, I will be assisted on-site by a post-doctoral resident in neuropsychology, and that the telecommunications service used for telepsychology is encrypted and HIPAA compliant by design.

I understand that I have the following rights with respect to telepsychology:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and/or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand that my withdrawal of consent may impact the timeliness of delivery of some services due to delays from rescheduling. I understand that the referring party and other entities will be notified of the situation, and that neuropsychologist is unable to specify the exact nature of those potential consequences.
2. The laws that protect the confidentiality of my medical and psychological information also apply to telepsychology. As such, I understand that the information disclosed by me during the course of my assessment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to: reporting child, elder, and/or dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that there are risks and consequences from telepsychology including, but not limited to, the possibility that despite the best efforts of the evaluator that: the transmission of my medical and psychological information could be disrupted or distorted by technical failures; the transmission of my medical or psychological information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telepsychology services may not be the same as face-to-face services. I also understand that if the evaluator believes I would be better served by another form of assessment services (e.g. face-to-face services), I will be rescheduled to a more appropriate date or referred to another evaluator who can provide such services in my area.
4. I understand that the benefits of telepsychology are comparable to face-to-face services, but as with face-to-face services results cannot be guaranteed or assured.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with Texas law, notwithstanding psychological test materials as provided in the Texas Psychological Practice Act or that I have agreed to above. I understand that while some portions of my examination may involve communications services, no portions will be recorded without my express consent. I also understand that the dissemination of any personally identifiable

images or information from the telepsychology interaction to researchers or other entities shall not occur without my written and specific consent.

Telepsychology does not remove the neuropsychologist from any responsibilities required by the Texas Psychologists' Licensing Act or Colorado Mental Health Practice Act. Telepsychology is used as an adjunct to face-to-face services, and allows psychologists to more easily provide psychological services in undeserved areas. Most research shows that telepsychology is about as effective as in-person services, but research in this area continues. If you have any questions regarding these services, you are encouraged to ask.