This informed consent contains information about the professional services and business policies of Dr. Emily. Please read this document carefully and ask any questions you have. You should only sign this document once you fully understand it. It will then be considered a binding agreement between you and Dr. Emily.

1. Please complete all forms on our website and bring them to your first appointment.
2. The cost of the initial 90-minute-long intake appointment is $600.00. The remaining balance will be due at your child’s first testing appointment.
3. You are fully responsible for payment for services at the end of each session unless other arrangements have been made in advance. Payment may be made by cash or check. Please make checks payable to Dr. Emily.
4. Testing may be conducted during a single day or over 2-3 sessions depending on the referral concerns. At the conclusion of testing, a feedback appointment will be scheduled to discuss the findings of the evaluation. Your child’s report will be released once payment has been made in full.
5. Please make sure your child has a good night’s sleep before testing. Also, have your child take all medications as scheduled on the testing day. This will help us have confidence in our results. Please feel free to bring snacks and drinks as there will be several short breaks during testing.
6. Your appointment time is reserved just for you. Dr. Emily or her office staff may contact you to provide appointment reminders as a courtesy; however, you are responsible for remembering your appointment. If you wish to change the time or day of your scheduled appointment, you must call our office to reschedule your appointment at least 24 hours in advance. Our office voicemail is always on to take your call and has a date/time stamp for all messages. There is a $150 cancellation fee for a missed appointment (i.e., a no show or cancellation without 24 hours’ notice). Please be aware that if you miss your appointment, it may be some time until you can be rescheduled. No other appointments will be scheduled until the cancellation fee is paid in full.
7. We do not accept insurance and therefore will not bill our services directly to your insurance carrier. Many health insurance policies do provide some coverage for neuropsychological testing. At the feedback session, you will be provided with a receipt for reimbursement, which you can submit to your insurance company. If you wish to apply for reimbursement, it is important that you find out what neuropsychological services your insurance policy covers. Authorization may be required prior to testing. You may wish to call your insurance company directly to find out their policies with regard to neuropsychological services. Collection of insurance benefits or any other arrangements regarding third party payment is your responsibility.
8. Please be aware that there will be a fee of $30 or 5% of the amount of the check (whichever is greater) for all returned checks. Until payment is received by cash or money order, no further appointments will be scheduled.
9. If your account is overdue/unpaid for more than 60 days, we have the option of using legal means to secure payment, including the use of a collection agency. If this should occur, we will provide you with the opportunity to pay prior to contacting the collection agency.
10. Any additional testing, attendance at school meetings, observations in schools, preparation of additional documents beyond the scope of the evaluation report (e.g., letters to GRE, SAT boards), and attendance at legal proceedings will be billed based on an hourly fee. These fees for additional services will be discussed with clients as the need arises.
11. In the case of separation or divorce, we will request that you provide us with a copy of the court order pertaining to custody prior to initiating services. Unless specifically limited by the court, both parents have the right to information about the child and the non-referring parent can request a copy of the report. Unless other arrangements are made in advance, the parent coming to the appointment is responsible for all financial obligations.
12. Many families use cell phones and email to make communication easier. Additionally, Dr. Emily may provide cell phone contact information to clients and may use her cell phone to return calls. It is very important to be aware that email and phone communication (including text messages) are not secure and can potentially be accessed by unauthorized people and, hence, have the potential to compromise privacy and confidentiality. Emails are not encrypted. Please do not include identifying information such as your child’s birth date or medical information in any emails you send us. If you choose to communicate with Dr. Emily or a member of the staff via email or cell phone, please consider the boundaries around the privacy that can be expected. In some cases, communication through cell phone or email may not be appropriate and, in those cases, an office visit may need to be scheduled.
13. If you have questions about our services or procedures, please contact us at 470-728-5778 and leave a message. We check messages on a regular basis and your call will be returned as soon as possible.
14. We cannot provide emergency services. In a life-threatening emergency, please call 911 or go to the nearest emergency room.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Please read and sign the statement below:

*I have read and understood the information and policies described in this form. I have also been given the opportunity to ask questions and have had my questions answered. I have been given a copy of this form for my records, and I consent to the agreed upon services for my child. I agree to meet all financial obligations.*

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| Parent/Guardian Signature |  | Relationship to Child |
|  |  |  |
| Child’s Name |  | Date |

**Notice of Privacy Practices**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we provide you with a Notice of Privacy Practices regarding the use and disclosure of Protected Health Information. The Notice of Privacy Practices requires that we obtain your signature acknowledging that we have provided you with this privacy information.

I have reviewed the privacy information covered in the Notice of Privacy Practices

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| Parent/Guardian Signature |  | Date |

**Archival Research**

On occasion, Dr. Emily publishes articles in professional neuropsychology journals and books to help improve patient care. The data in this evaluation may be used for such purposes and published in professional sources as “archival research.” These data are published “blindly” meaning that no identifying information is published about any patient. Dr. Emily’s services shall not be influenced by, or predicated on, your consent to such research participation. If you agree to allow your child’s data to be used for purposes of archival research, please read and sign the statement below:

I understand that my child’s treatment shall not be influenced by, or predicated on, consent to research participation. I understand the above information and hereby agree to allow my or my child’s data to be included in “archival research.”

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| Parent/Guardian Signature |  | Relationship to Child |
|  |  |  |
| Child’s Name |  | Date |