Oakland Neuropsychology Center

Isabelle Beaulieu, Ph.D., Director

Divorced Client Informed Consent

Acknowledgment of Receipt of Privacy Practices Notice

I,_____, acknowledge having received the Notice of Privacy Practices of Oakland Neuropsychology Center, and/or I have been given an opportunity to read Oakland Neuropsychology Center's Notice of Privacy Practices. I understand that if I have any questions, I can direct them to Dr. Isabelle Beaulieu.

Signature_____ Date_____

This agreement concerns_____(name of patient). I understand that these services may include direct, face to face contact, interviewing and/or testing. They may also include the psychologist's time required for the reading of records, consultation with other professionals, scoring of tests, interpreting the results, report writing and any other activities to support these services.

Nature and Purpose of Assessment: The goal of the neuropsychological assessment is to measure attention, memory, language, problem solving, or other cognitive and psychological/emotional functions. A neuropsychological assessment may point to cognitive/emotional difficulties and suggest possible methods and treatments or accommodations. In addition to an interview where we will be asking you questions about background, academic history, mental health and current medical symptoms we may be using different techniques and standardized tests, including but not limited to, asking questions about knowledge of certain topics, reading, drawing figures and shapes, listening to recorded tapes, viewing printed material and manipulating objects.

Foreseeable Risks, Discomforts and Benefits: For some individuals assessments can cause fatigue, frustration and anxiousness.

Informed Consent for Treatment

I hereby agree and consent to participate in treatment/testing services provided by Oakland Neuropsychology Center. If the client is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and/or I am legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____ Date_____

Relationship to client (if applicable)_____

Phone Number:_____ Email:_____

I understand that I may call Dr. Beaulieu at any time during this process if I wish to contribute information regarding my child and/or obtain results. I understand that each meeting with individual parents, as well as any and all communications by parents with our clinic, will be treated confidentially and that information shared with Dr. Beaulieu may be included in my child's treatment records.

Signature_____ Date_____

As part of our clinic policies, we request that a copy of the current custody decree be provided prior to the initial interview.

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