Oakland Neuropsychology Center
Isabelle Beaulieu, Ph.D., Director
4190 Telegraph Rd, Suite 2700, Bloomfield Hills, MI 48302 Phone: 248-644-9466 Fax 248-522-7365

Divorced Parent Consent

I,_____, agree to allow the psychologist, Dr. Isabelle Beaulieu, to perform the following services:

_____Neuropsychological testing, assessment or evaluation and report writing.

_____School Visit and consultation with school personnel.

_____Other (describe)_____

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. I understand and agree that both parents must provide signed consent to release any records, as this is in the best interest of the child.

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

Service Costs:

90791 Diagnostic Interview (First Visit) $300

96136, 96137,96132, 96133 Neuropsychological testing and evaluations services $275/hour

96138, 96139 Neuropsychological testing by an examiner, $255/hour

Full Assessments typically range from $2,800 to $3,500, although it may be more or less, depending on the reason for the assessment and duration of testing.

Professional Fees: If you become involved with legal proceedings that require Dr. Beaulieu's participation, you will be expected to pay for any professional time Dr. Beaulieu spends on your legal matter, even if the request comes from another party. Dr. Beaulieu charges $270/per hour for professional services she is asked or required to perform in relation to your legal matter. A copy fee of $50 will be charged for record requests.

Billing and Payment: Fees are collected at the time of service. If your account has not been paid for more than 60 days and arrangements for payment has not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going to small claims court. (if such legal action is necessary, its costs will be included in the claim).

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law. Other foreseeable limits to confidentiality for this assessment include:

_____

_____

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_____ **Date**_____

Patient Signature (if 14 years or older)

Signature_____**Date**_____

Parent/Guardian or Authorized surrogate (If applicable)

Witness_____ **Date**_____