glassman
NEUROPSYCHOLOGY
ASSOCIATES LLC

2448 S. 102nd Street
Suite 270
West Allis, WI 53227
Phone: 414.444.9811
Fax: 414.444.9822

To Our Patients:

In continuing efforts to protect public health as well as the health of our staff and patients, effective Monday, June 15, 2020 we will offer two options for receiving services from our office: 1) online services conducted remotely, or 2) in-office visits with additional safety measures in place to limit inter-person contact.

Please read the attached *Informed Consent for In-Person Services During Covid-19* or go to our website at glassmanneuropsychology.com to determine which service is best for you.

For evaluation and assessment services, testing can be scheduled on Mondays, Wednesdays, or Fridays. These are full day appointments and generally last from 9am to 4pm including a break for lunch. If you opt for web-based services, there may be additional time needed for testing requiring two separate appointments. The time needed for testing will be finalized when your on-line appointment is scheduled.

For all appointment types, we request necessary documentation be provided **10 business days prior to the scheduled appointment time.** This may include, but is not limited to:

- A copy of your insurance card
- Letters supporting the payment of services requested
- Psychological treatment or medical records
- Previous psychological or neuropsychological evaluations
- Legal documents pertaining to the services requested
- School or academic records

If we have requested information from you prior to your visit and it is not received **10 business days prior to the scheduled appointment time** your appointment may be rescheduled for a later date.

For all appointments, please complete and sign the following documents included in this document:

- General Informed Consent for Services (will be reviewed at the time of your appointment)
- Informed Consent for In-Person Services (if you choose this option)
- Patient Registration Form with a **front and back copy of your insurance card**
- Notice of Privacy Practices
- Receipt of Notice of Privacy Practices

Payment for Evaluation

We accept checks and all major credit and debit cards. If you are paying through your insurance, we will submit your expenses to your insurance company through our billing service.

Release of Information/ Authorization for Use/Disclosure of Health Information

If you have:

- Received psychological services in the past including, but not limited to, individual therapy, psychological testing/assessment, inpatient or outpatient mental health treatment
- An Individualized Education Plane (IEP) or 504 Plan
- A medical condition that may be impacting your psychological health (ie. head/brain injury, chronic illness, neurological disorder)

Please complete a Release of Information form authorizing Glassman Neuropsychology Associates to receive your treatment/care records including the name and location of the organization or person who retains these records.

Thank you in advance as we all venture together into this "new normal" – at least for now.

Again, please do not hesitate to contact us if you have any questions or concerns.

Be Well,

Susan Taylor, MS
Office Manager
Glassman Neuropsychology & Associates LLC
414.444.9811

Instructions for Online Evaluations

For your online evaluation, we have a few easy instructions to get ready for your meeting:

- Be ready on time – log in to your email on your laptop or tablet (no cell phones)
- Watch for the doxy.me link from Glassman Neuropsychology Associates to join the meeting
- Be well-rested
- Have a beverage and snack available
- Have paper and a pencil or pen ready to go
- Be in a quiet, well-lit space

If the patient is under the age of 12, please have a parent or guardian nearby to assist if necessary.

Remember, if you opt for web-based services, there may be additional time needed for testing requiring two separate appointments. The time needed for testing will be finalized when your on-line appointment is scheduled.

For evaluation and assessment services, testing can be scheduled on Mondays, Wednesdays, or Fridays. These are full day appointments and generally last from 9am to 4pm including a break for lunch.

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Patient Registration Form

(Please Print)

Today's Date: _____

PATIENT INFORMATION						
Patient's Name			Marital Status			
LAST:	FIRST:	MIDDLE:	Single Married Divorced	Separated Widowed		
Date of Birth:	Sex:	Phone #:	Alternate Phone:			
Street Address:		City:	State:	Zip Code:		
Occupation:	Employer:	Employer Phone #:				
Referral Source:	Reason for Referral:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Person responsible for bill *If same as above only fill out **BOLD** sections on next page, if different than above please complete this entire section.					
LAST:	FIRST:	MIDDLE:	Date of Birth:		
Street Address:		City:	State:	Zip Code:	

INSURANCE INFORMATION CONT. **All patients, please complete all sections below.**		
Employer:	**Employer Address:**	**Employer Phone :**
Is this patient covered by insurance:	**Patient's Relationship to Subscriber:** **Self Child** **Spouse Other:_____**	
Name of Primary Insurance:	**Subscriber's Name:**	
Member ID/Policy Number:	**Group Number:**	
Secondary Insurance (complete is applicable)		
Name of Secondary Insurance:	**Subscriber's Name:**	
Member ID/Policy Number:	**Group Number:**	

EMERGENCY CONTACT INFORMATION	
Name of Local Emergency Contact:	Relationship to Patient:
Home Phone #:	Work Phone #:

PATIENT REGISTRATION CONTINUED:

1. *I understand that I am responsible for the full amount billed for the services provided.*
2. *I authorize direct payment to my service provider.*
3. *I hereby permit a copy of this to be used in pace of an original.*

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount, or any other balance not paid by your insurance on the day and time service is provided. There will be a $45.00 service charge on all returned checks. In the event that your account goes to collections, there may be a 20% collection fee added to your balance.

There is a 24-hour cancellation policy which requires that you cancel your appointment 24 hours in advance between the hours of 8AM and 5PM, Monday through Friday, to avoid being charged $45.

CONSENT TO PSYCHOLOGICAL CARE

I, having legal responsibility and authority and knowing that I am in need of outpatient psychological services and do authorize Dr. Nathan Glassman and/or his associates, assistants, or designees to perform and prescribe such treatment and/or assessment as deemed advisable under the circumstances. I understand that my psychologist(s) may not be employed by this agency. It is also understood and agrees that at times students under the supervision of authorized agency personnel may deliver services. The arrangements of unemployed psychologists and students are detailed in the HIPAA Notice of Privacy Practices. I authorize Dr. Nathan Glassman and/or his office assistance and/or those associates involved in my treatment to contact others involved in my care, including but not limited to my primary care physician regarding information pertaining to psychological and emotional functioning.

Patient/Guardian Signature:	Date:

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NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION: Glassman Neuropsychology Associates LLC, may use your health information, that is information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. We have established a policy to guard against unnecessary disclosure of your health information.

EXAMPLES OF CIRCUMSTANCES IN WHICH HEALTH INFORMATION MAY BE USED AND DISCLOSED:

- To provide treatment
- To obtain payment
- To conduct health care operations

Further information on these uses of health care information is available from Glassman Neuropsychology Associates LLC, at your request

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION: Other than as stated above, Glassman Neuropsychology Associates LLC, will not disclose your health information other than with your written authorization. If you or your representative authorizes Glassman Neuropsychology Associates LLC, to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION: You have the following rights regarding your health information maintained by Glassman Neuropsychology Associates LLC:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Glassman Neuropsychology Associates LLC's disclosure of your health information to someone who is involved in your care or the payment of your care. However, Glassman Neuropsychology Associates LLC, is not required to agree to your request. If you wish to make a request for restrictions, please contact Office Manager, at 414-444-9811.

Right to Receive Confidential Communications: You have the right to request that Glassman Neuropsychology Associates LLC, communicate with you in a certain way. For example, you may ask that communications pertaining to your health information be done privately with no other family members present. If you wish to receive confidential communications, please contact Office Manager, at 414-444-9811.

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to Office Manager, at 414-444-9811. If you request a copy of your health information, Glassman Neuropsychology Associates LLC, may charge a reasonable fee for copying and assembling costs associated with your request. These costs are $.1.00 per page.

RECIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have received a copy of Glassman Neuropsychology Associates LLC's, Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Glassman Neuropsychology Associates LLC, and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient/Guardian Signature:	Date:

This document contains important information about our decision to resume in-person services in light of the COVID-19 public health crisis on a case by case basis. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between us (yourself and Glassman Neuropsychology Associates LLC).

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, it may be required to meet via telehealth. If you have concerns about meeting through telehealth, this can be discussed with your provider and we will try to address any issues or concerns. You understand that, if we believe it is necessary, we may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect your decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so billing and/or reimbursement for services may need to be reviewed.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, our staff, and our families, as well as other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. _____
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you

agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. ____

- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. _____
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ____
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit._____
- You will wear a mask in all areas of the office (I [and my staff] will too). _____
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. _____
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. _____
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. _____
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. _____
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth._____
    - If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or a Member of Our staff are Sick

You understand that we are committed to keeping you, our staff, and all of our families safe from the spread of this virus. If you show up for an appointment and a member of our staff believes that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If a member of our staff tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

Patient/Guardian Signature:	Date:

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Office Safety Precautions During COVID-19 Pandemic

Our office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

Effective June 2020, Glassman Neuropsychology will transition to a hybrid-office/telemed business model including the option for either online or in-office evaluations with health precautions including the following:

- My staff pre-screens patients before making an appointment about exposure risks including travel, group participation or exposure to people with confirmed cases of Coronavirus.
- My staff pre-screens patients on the day of their appointment for symptoms including cough, fever, shortness of breath and other respiratory illness or feeling unwell.
- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- My staff and I wear masks.
- My staff maintains safe distancing, including using plexi-shields when necessary.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Exposure is limited to 45 minutes for any testing requiring 2 people participation.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

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Evaluation and Treatment Fee Schedule

Fee Schedule	
Initial Diagnostic Interview	$250.00 per 45 – 50 Minutes Session
Individual Psychotherapy Session	$190.00 per 45-50 Minutes Session $270.00 per 75-80 Minutes Session
Family Therapy Session	$190.00 per 45-50 Minutes Session
Psychological Evaluation	$300.00 per 60 Minutes
Neuropsychological Evaluation	$350.00 per 60 Minutes

Terms: The fees listed are before insurance and/or other forms of payment are taken into consideration. Fees for psychological and neuropsychological evaluations vary according to the number and type of tests administered, and the time needed for scoring, interpretation, reporting and consulting on them.

I understand that I am financially responsible for any portion of the bill which will not be covered by my insurance company or other 3rd parties.

I have read and understand this Fee Schedule and its' terms.

Patient/Guardian Signature:	Date:

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Release of Information
Authorization for Use/Disclosure of Health Information

Patient Name: Date of Birth:

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize the listed person(s), organization(s) and/or health care provider to use or disclose my treatment records and/or health information during the term of this Authorization to the recipient(s) that I have identified below.

Disclosure: I authorize the following person(s), organization(s) and/or health care provider to release/disclose my treatment records and/or health care information:

Name: _____

Address: _____

Date(s) of Treatment: _____

Recipient: I authorize my treatment records and/or health care information to be released to the following recipient(s):

Name: Glassman Neuropsychology Associates LLC.

Address: 2448 S 102nd St #270, Milwaukee, WI 53227

Purpose: I authorize the release of my health information for the following specific purpose (Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization):

- Legal
- Personal Record
- Continuity of Care
- Other: _____.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health/treatment information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- ❑ Only the following records or types of health information:

  _____

  _____

  _____

Term: I understand that this Authorization will remain in effect:

- ❑ A period of six (6) months from the date on which this authorization is signed.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Glassman Neuropsychology Associates LLC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Glassman Neuropsychology Associates LLC. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. If this authorization was obtained as a condition for providing treatment or evaluation, such as in the case of court ordered evaluations, then a revocation will not be effective.

Non-health care providers: I understand that organization(s) that are not health care providers or affiliated organizations are not subject to federal privacy standards. As such, my health information disclosed pursuant to this authorization may no longer be protected by federal privacy standards if the recipient(s) are not bound by federal privacy standards. Such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

I understand that Glassman Neuropsychology Associates, LLC, may receive direct or indirect remuneration in connection with the use and/or disclosure of my health information. Such remuneration is governed by usual and customary fees charged for psychological services or reasonable fees for copying records to release information.

Questions: I may contact Glassman Neuropsychology Associates LLC for answers to my questions about the privacy of my health information at 2448 S 102nd St #270, Milwaukee, WI 53227, or by telephone at (414) 444-9811.

_____	_____	_____
Signature	Date	Signature of Witness

If individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness

Informed Consent for Neuropsychological/ Psychological Services

Welcome to Glassman Neuropsychology Associates LLC. This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician or his/her supervisor. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment. The clinic is a training facility and our students may be involved in providing services. Our students are under the supervision of our licensed psychologists with expertise in neuropsychological and psychological testing.

PSYGHOLOGY SERVICES

THERAPY

Psychotherapy varies depending on the personalities of the psychologist and patient, and your particular concerns or issues. There are many different methods to deal with problems, but for therapy to be most successful you will have to work on thing both during our session and at home.

Psychotherapy can have risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings in distress. But there are no guarantees of what you will experience. You have a right to be informed of the benefits of treatment, the possible side effects of treatment, alternatives to treatment, and the probably consequences of not receiving treatment as well as a right to withdraw from treatment.

We usually conduct an evaluation that will last for one to two sessions. You and your clinician can then decide if they are the best person to provide your services. By the end of the evaluation, we can develop a treatment plan. If psychotherapy is begun, it will usually be one 50-minutes session per week or every other week.

ASSESSMENT/TESTING

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you in for assessment. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations. The assessment process generally involves

an informational interview followed by the administration of one or more neuropsychological or psychological tests.

Although it is generally possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed and a report will be written. You will then have the opportunity to meet with your clinician to discuss the results and receive a copy of the report.

If you are receiving assessment services as the result of a referral from a separate agency (ie. FAA, DVR, SaintA's) the final report may be submitted directly to the agency.

CONTACTING US

Although we are often not immediately available by phone, you can leave a message at (414) 444-9811. The telephone is usually answered by office personnel from 9:00 am to 4:00pm Monday through Friday. In case of an urgent matter or an emergency situation please contact your family physician, call 911, or call this hotline (414) 257-7222.

PROFESSIONAL RECORDS

We keep Protected Health Information (PHI) about you in your records. Under HIPPA rules, this record constitutes your Clinical Record. It includes the following information: reasons for seeking services; a description of your problem; diagnostic treatment goals and progress; medical, social, and treatment history; billing records; and any reports sent to anyone including your insurance carrier. If receiving assessment/testing services, this will include your testing protocols, the results of your testing, and the final report.

If receiving psychotherapy services, a set of Psychotherapy Notes may also be retained. These notes are for our own use to help us provide the best treatment, and can include the content and analysis of conversations has in therapy sessions. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your records, if you request it in writing. We recommend that you initially review them in the presence of your clinician, or have them forwarded to another mental health professional so you can discuss the contents.

Portions of your clinical record may be used to support research projects conducted by clinicians at Glassman Neuropsychology Associates. None of your protected health information (PHI) will be utilized in these endeavors as any data reviewed for research will be de-identified and discussed in terms of trends and patterns.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements of state law and HIPAA. There

are other situations that require only that you provide written; advance consent. Your signature on the Agreement provides consent for the following activities:

- Center staff may see your records in the course of their clerical duties. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the Center except as noted in this Agreement.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere.
- If a patient threatens to harm himself/herself, we may be obliged to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If you receive services from a student/trainee, they will receive regular supervision from a licensed psychologist who has access to your Clinical Record and Psychotherapy Notes.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If we receive a court order
- If a government agency is requesting the information for health oversight activities
- If we need to defend myself against a patient complaint or lawsuit
- If an employer requests information regarding the worker's compensation claim of a patient.

There are some situations where we may have to reveal information about a patient's treatment in order to take legally obligated action to protect others from harm:

- If we have reason to believe that a child that we have seen has been abused or neglected or has been threatened with abuse or neglect that we believe is likely to occur, the law requires that we file a report with the appropriate governmental agency
- If we have reason to believe or suspect that abuse, material abuse or neglect of an elder adult has occurred, the law allows us to file a report with the appropriate government agency
- If we believe that a patient presents a foreseeable risk of harm to another, we may have to take protective actions including notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to the minimum necessary.

MINORS AND PARENTS

Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records unless we decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to progress, particularly with teenagers, it is our policy to request an agreement from parents to give up their access to their child's records. If they agree, we will provide them with general information about the progress of the child's treatment, and his/her attendance at

scheduled sessions. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

PROFESSIONAL FEES, BILLING, AND PAYMENTS

Fees and billing practices are outlined in the *Patient Registration Form* and the *Evaluation and Treatment Fee Schedule.*

Fee Schedule	
Initial Diagnostic Interview	$250.00 per 45 – 50 Minutes Session
Individual Psychotherapy Session	$190.00 per 45-50 Minutes Session $270.00 per 75-80 Minutes Session
Family Therapy Session	$190.00 per 45-50 Minutes Session
Psychological Evaluation	$300.00 per 60 Minutes
Neuropsychological Evaluation	$350.00 per 60 Minutes

A complete (neuro)psychological evaluation involves the initial appointment, completion of any surveys/tests sent to be completed remotely, and testing measures with the examiner. Testing also involves scoring and interpretation of the results and the preparation of an integrative written report. The writing of the report usually takes at least as many hours as and often even more hours to complete than the testing time itself and will be billed accordingly.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided.
- You have been informed of the limits of confidentiality.
- You understand and agree to the payment and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Patient/Guardian Signature:	Date:
Printed Name:	Relationship to Patient: