

**INFORMED CONSENT FOR NEUROPSYCHOLOGICAL TESTING**

I, Dr. Deborah Budding, will be administering psychological tests to \_\_\_\_\_, the child for whom you are responsible. If you have questions about psychological testing, please discuss them with me. It is important that you, the adult who is legally responsible for the above mentioned child (henceforth, "my child,"), understand several aspect of this process. Please initial each item below to indicate that you have read it carefully and understand it.

\_\_\_\_\_1) I understand Dr. Budding will conduct an evaluation of my child consisting of standard psychological and neuropsychological tests.

\_\_\_\_\_3) I understand that the cost of this evaluation is \$4,600. This fee covers meetings comprising an initial consultation, up to 10 hours of test administration and one feedback session. I understand that when she performs services beyond these that are customary, her fee of \$360 per hour will apply, but Dr. Budding will not do this additional work without my consent. I agree to pay the costs of evaluation directly, and whatever additional costs, if any, to which I consent. I understand that gaining reimbursement from my insurance company is my responsibility and that Dr. Budding will provide me with paperwork necessary for me to do so.

\_\_\_\_\_4) I understand that Dr. Budding will write a formal evaluation of my child based on the results of testing, and will dictate this report to a transcriptionist. The transcription process can take up to four to six weeks to complete, but verbal feedback prior to completion of the written report is available to facilitate treatment planning. I understand that Dr. Budding will provide me with a copy of the evaluation, and she will meet with me to discuss its results. The report will also be available to be requested by other professionals, and she will send it to them upon my written request and consent.

\_\_\_\_\_5) I understand that if I or my child discloses certain types of information to Dr. Budding, she may be required by state law or permitted to communicate this information to other people. Types of information that can mandate or allow this breach of confidentiality include reports of child or elder physical/sexual/emotional abuse and threats my child may make of intending to harm him/herself or to harm another person.

\_\_\_\_\_6) I understand that Dr. Budding is performing an evaluation only. Her doing so does not imply that she will treat my child, if treatment is indicated. She will, however, recommend professionals from whom my child can receive whatever services may be indicated. I understand that Dr. Budding does not formally advocate on behalf of children with school districts, but will be available to consult with advocates and school districts regarding the child's assessment results as requested. Dr. Budding may at times attend IEP meetings as appropriate at her usual and customary hourly fee.

\_\_\_\_\_7) I understand that Dr. Budding may wish to speak with or get records from third parties whose names I provide as part of this evaluation, and that she will not do so without my written consent.

CONSENT AGREEMENT: I have read, understood, and agree to each of the previous items. I have asked questions about any part that caused me concern or I did not understand fully. By signing below I indicate that I understand and agree to the nature and purpose of this evaluation, how it will be reported, and to each of the points enumerated above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date