833 Market Street, Suite 809
San Francisco, CA 94103
TEL: 415.627.9095
FAX: 415.627.9108
www.sfbraindoc.org

INFORMED CONSENT FOR PSYCHOLOGICAL/NEUROPSYCHOLOGICAL EVALUATION, RESEARCH, AND/OR TREATMENT

Patient Name ______________________________ Date of Birth __________________

Consent for Evaluation and Treatment

I give permission to San Francisco Neuropsychology, PC (SFN, PC) and its agents or employees to provide clinical services as needed for me and/or my minor child/ward. I have discussed all of the relevant reasons for requesting the evaluation and/or treatment and understand the services that will be provided. I understand that, for valid test results, I must provide my best effort, which will also be assessed. **Initials**______

I understand that __________________________________ is an assistant and is working under the supervision of a licensed SFN, PC professional. **Initials**______

I give permission to audio record portions of the examination for scoring accuracy. **Initials**______

I consent to the confidential use of my evaluation for research for professional and scientific purposes as long as information is not associated with any of my personally identifying information. **Initials** _____

I provide consent to receive a Patient Satisfaction Survey by email at ____________________________. I understand that this short survey is intended to help improve the services provided and will not be associated with the neuropsychological evaluation. **Initials** _____

Consent for Release of Confidential Information

The referring physician will receive the report. I authorize SFN, PC and its agents or employees to receive information from and disclose information to:
Name & Contact Info: ____
Name & Contact Info: ____
Name & Contact Info: ____
The following information: clinical records and/or information necessary for the filing of insurance claims. I understand that I/my child am/is protected by Federal Law from the secondary release of medical/mental health information by the insurance carrier. **Initials** _____

Limits of Confidentiality

I have been informed and understand that information conveyed to my SFN, PC doctor(s), its agents or employees is confidential except in the following situations according to California State Law:

A. If I/my child communicate(s) to SFN, PC doctors, agents, or employees that a serious threat to harm an identifiable person is intended, the identified person and the police must be warned;
B. If SFN, PC doctors, agents, or employees suspects child abuse or neglect, or abuse of a helpless adult or elder, a report must be made to the appropriate agency;
C. and if I/my child appear(s) to be in danger to my/him/herself or others, hospitalization may be necessary.

Initials_____

Litigation and Confidential Information

I understand that:

A. Information and records, otherwise confidential, or testimony concerning me/my child must be provided in the event or a court order;
B. In litigation or official proceedings, information and records, otherwise confidential or testimony concerning me or my child may have to be provided in limited circumstances without my specific consent, in accordance with applicable law.

Signature: __________________________________ Date: __________________