Cognitive Assessment & Referral Services PLLC

NEUROCOGNITIVE EVALUATION CONSENT FORM

Patient Name: ____

This form contains information about a Neurocognitive Evaluation. If you have any questions regarding the information contained in this form, please ask before signing.

Nature and Purpose of Evaluation
The goal of the Neurocognitive Evaluation is to determine if any changes have occurred in your cognitive, emotional, behavioral, and/or physical functioning, and if so, the extent of the changes. The evaluation will also provide possible methods and treatments for rehabilitation, as well as suggestions for supportive services if needed. In addition to an interview where you (and family members, if you choose) will be asked questions about your personal background and medical symptoms, you will be asked to complete various standardized tests (mostly paper and pencil) and asked to fill out questionnaires to assess the nature and extent of any medical and/or psychological problems that may be affecting your current level of functioning. Family members are encouraged to be present during the interview portion of the assessment, but are not allowed in the room during testing.

Confidentiality
Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including:

- A statement of intent to harm yourself or others
- Statements indicating harm or abuse of children or vulnerable adults
- Issuance of a subpoena from a court of law
- Information shared with insurance companies for the purpose of payment

Potential Risks
The testing process can take 3 to 4 hours to complete. Some people may experience fatigue, frustration, or anxiety. All efforts will be made to keep you as comfortable as possible and you will be provided with breaks as needed.

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.

______________________________	____________________
Patient Signature	Date
______________________________	____________________
Guardian Signature (if applicable)	Date
______________________________	____________________
Witness Signature	Date