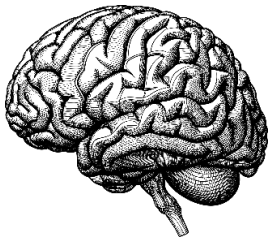

GKB Neuropsychology

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NEUROPSYCHOLOGICAL EVALUATION INFORMED CONSENT

Patient Name: _____ **DOB:** _____ **Date:** _____

Purpose And Nature of Neuropsychological Assessment

What is a Neuropsychological Evaluation?
A neuropsychological evaluation is a comprehensive assessment of cognitive, emotional, and behavioral functioning as it relates to brain function. The purpose is to:

- Determine current neurocognitive strengths and weaknesses
- Assist with diagnosis and treatment planning
- Provide recommendations for intervention, accommodations, or rehabilitation
- Establish a baseline for future comparison

A typical evaluation includes a clinical interview, standardized testing, effort and validity measures, behavioral observations, review of relevant records, and a feedback session summarizing findings and recommendations.

Testing Procedures
Testing may involve interview questions, paper-and-pencil and computerized tasks, drawing or problem-solving activities, and measures of attention, memory, and reasoning. Breaks are provided as needed. Evaluations may occur in the office, at a facility, or in a home setting. Testing sessions typically last 4 – 8 hours and may be divided across appointments.

Language and Cultural Considerations
Evaluations can be conducted in English, Polish, or both. Because most instruments are normed for English-speaking individuals, language and cultural factors will be considered carefully in interpretation. Any limitations will be noted in the report.

Test Validity and Security
Effort and performance validity measures are routinely included to ensure results reflect best effort. These are standard and not meant to imply dishonesty.

All test materials are copyrighted and may not be copied or released. Only formal test scores and interpretations are included in your report.

Raw test data and protocols are professional materials and may only be released to a licensed psychologist upon your written authorization. Copies of answer sheets, test booklets, or other materials are not released directly to patients or third parties to preserve test security and integrity.

Motivation, fatigue, pain, medication effects, and emotional factors may influence results. These influences are discussed when interpreting findings.

Risks, Limitations, and Influencing Factors
The evaluation is non-invasive but may be tiring or frustrating. Discuss any concerns or need for breaks during testing.

Results can be affected by medical conditions, medications, fatigue, stress, mood, motivation, or educational and cultural background.

The evaluation cannot guarantee specific outcomes or diagnoses and does not replace medical testing. Interpretation is based on the information available at the time of assessment.

Voluntary Participation and Right to Withdraw
Participation is voluntary. You may withdraw consent or decline any portion of testing at any time.

If you withdraw before completion, you are responsible for payment for services already provided. Partial results may be summarized if clinically appropriate.

You are encouraged to ask questions at any time before, during, or after the evaluation. You may request clarification about any procedure, recommendation, or part of this document.

Confidentiality and Limits
All information is confidential and protected by federal and state law. Records will only be released with your written authorization, except as required by law in cases of:

- Risk of serious harm to self or others
- Suspected child, elder, or dependent-adult abuse
- Court order or other legal mandate
- Insurance requirements for claims processing

For referred evaluations, reports may be shared with the referring provider.

For self-referrals, reports are released only to you unless otherwise authorized.

In legal or worker's compensation cases, reports are sent directly to the referring attorney or representative.

If subpoenaed, reasonable efforts will be made to notify you, though compliance may be legally required.

If you choose to use insurance benefits, your insurance company may request information about diagnosis, services provided, and clinical findings to determine coverage or to conduct audits. By using insurance, you understand that some information from your record may be shared with the insurer as required for payment and quality review.

Scope of Services and Emergency Procedures
This evaluation is for assessment purposes only and does not constitute therapy or treatment.

If psychological treatment or medication management is needed, referrals can be provided.

GKB Neuropsychology does not provide emergency services.

If you experience a medical or psychiatric crisis:

- Call 911 or go to the nearest emergency department
- Contact the 988 Suicide & Crisis Lifeline
- Notify your primary physician or mental-health provider

In some situations, a third party such as a physician, attorney, insurance carrier, or agency may request this evaluation. In those cases, my primary role is to provide an independent clinical assessment and report for that party. This evaluation does not create a long-term treatment relationship and I may have a duty to share relevant findings with the referring party as outlined in this consent and any separate release of information that you sign.

Fees and Financial Responsibility
You have received information regarding fees, insurance billing, and estimated costs.

Payment is due at the time of service unless other arrangements are made.

You are responsible for all copays, deductibles, and charges not covered by insurance.

Appointments cancelled with less than 48 hours' notice may be subject to a cancellation fee.

Full details are provided in your financial policy form.

Reports and Feedback
A written report is generally available within approximately 2 – 4 weeks of your final testing session.

At feedback, results and recommendations will be reviewed and copies provided as appropriate.

Reports are distributed only to authorized parties consistent with confidentiality policies and written releases.

If you are re-evaluated at a later date, prior results may be referenced for comparison. Updated consent will be obtained before any additional testing. Reports are intended for clinical use and should not be distributed or interpreted by third parties without written authorization.

If new information emerges after the report is issued, an addendum may be prepared at the clinician's discretion to clarify findings or incorporate updated data.

Reports are written for clinical and professional audiences. They should not be modified, excerpted, or redistributed in a misleading way. If a third party has questions about the report, they should contact me directly for clarification with your written permission.

Record Retention and Access
Records are kept for a minimum of seven years after the last date of service (or until age 25 for minors).

You may request copies of your records; reasonable fees may apply. Access may be limited if release would likely cause harm to your physical or mental well-being.

Your HIPAA Rights Include:

- The right to access and copy your records
- The right to request corrections or restrictions
- The right to file a complaint with the U.S. Department of Health and Human Services if you believe your privacy rights were violated

After the retention period, all records are destroyed securely.

Communication, Telehealth, and Observation Policies
Routine communication may occur through secure email or phone. Urgent or emergency issues should not be communicated electronically.

Electronic communication is not encrypted and may involve limited security risks. By consenting to communicate electronically, you acknowledge and accept these risks.

If telehealth is used for any portion of the evaluation, you are responsible for maintaining privacy, ensuring a quiet and distraction-free environment, and confirming adequate technology.

Technical issues may require rescheduling.

Observers may be allowed only when clinically appropriate and agreed upon in advance. Their presence will be documented in the report.

Special Circumstances
Additional fees may apply for expedited reports, legal testimony, travel to facilities, or other administrative services.

Potential conflicts of interest between multiple parties will be discussed and resolved before evaluation proceeds.

Any substance-use information disclosed in this evaluation is protected under federal law (42 C.F.R. Part 2). Such information cannot be further disclosed without your written consent, except as permitted by those regulations. These rules also restrict the use of substance-use information to investigate or prosecute you for any alcohol- or drug-related offense.

HIPAA Notice Acknowledgment
I acknowledge that I have been offered or provided a copy of the Notice of Privacy Practices (HIPAA Privacy Policy Statement) for George K. Bialkowski, Psy.D., PLLC *d/b/a* GKB Neuropsychology. I understand that this Notice describes how my health information may be used and disclosed, and how I may access that information. I have had the opportunity to ask questions about the Notice, and all questions have been answered to my satisfaction.

ACKNOWLEDGEMENT & CONSENT

By signing below, you acknowledge that you have read and understood this document, that your questions have been answered, and that you consent to undergo neuropsychological evaluation with George K. Bialkowski, Psy.D., PLLC *d/b/a* GKB Neuropsychology under the terms described:

- ☐ I understand the purpose, procedures, and potential risks of this evaluation.
- ☐ I understand the limits of confidentiality and my rights under HIPAA.
- ☐ I have been offered or provided a copy of the Notice of Privacy Practices (HIPAA Privacy Policy Statement).
- ☐ I have reviewed and agree to the Financial Responsibility and Payment Policy for GKB Neuropsychology.
- ☐ I have received information about fees and billing practices and understand that I am financially responsible for services rendered.
- ☐ I consent voluntarily to participate in this neuropsychological evaluation.

Patient Signature (if 18 or older): _____ **Date:** _____

Parent/Guardian Signature (if patient under 18): _____

Clinician / Evaluator Signature: _____ **Date:** _____

Clinician / Evaluator Printed Name: George K. Bialkowski, Psy.D. **License #:** 071 – 009240