CONSENT FOR NEUROPSYCHOLOGICAL TESTING

Child's Name: _____ Birth Date: _____

I certify that I am the custodial guardian of the above named child, and hereby give my authorization and consent for the above named child to receive neuropsychological testing by Lindy S. Pottinger, Ph.D., Pediatric Neuropsychologist. I understand that as the parent and/or custodial guardian of the above named child, I am entitled to an explanation of the testing, and feedback regarding the results. I understand that there is a fee for the testing, and agree to pay $ 2200.00 for the assessment. The assessment will consist of:

a) A clinical interview with the child's parent(s) or custodial guardian
b) A behavior rating scale completed by the child's parent(s) or custodial guardian
c) A selected battery of neuropsychological tests
d) A feedback session with the child's parent(s) or custodial guardian
e) A detailed report explaining the assessment findings

I understand that any services, other than those set out above, will be billed at $250.00 an hour.

_____ _____ _____
Signature Relationship Date