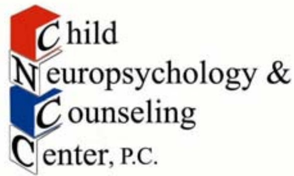

CONSENT FOR NEUROPSYCHOLOGICAL TESTING

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 any co-pay or amount not paid by the insurance company. 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) One feedback session with the child's parent(s) or custodial guardian
e) A detailed report explaining the assessment findings

Any additional services will be billed at $250.00 per hour.

____________________ ____________________ ___________
Signature Relationship Date