BAYCARE CLINIC®
NEUROPSYCHOLOGY

Informed Consent for Evaluation

Patient Name: _____ Date of Birth: _____ MRN: _____

1. **Consent to evaluation:** The patient will be evaluated by professionals with a doctoral degree in psychology and specialized training in neuropsychology. A psychometrist, who has been trained in neuropsychological testing may administer tests to the patient as part of the evaluation. The psychometrist works under the supervision and direction of the neuropsychologist who will be able to observe your evaluation with the psychometrist remotely via a live-stream feed.

2. **Benefits to evaluation:** This evaluation may be used to identify a diagnosis, evaluate recovery or treatment, estimate prognosis, and/or assist in education and rehabilitation planning. It is for the patient's benefit (as well as the referring professional) to understand the nature and cause of any difficulties affecting the patient's daily functioning. This understanding may assist in identifying appropriate recommendations and treatments to be offered. I have been provided information and time to study the information or seek additional information to my satisfaction regarding: (a) The benefits of the proposed evaluation; (b) The way the evaluation is to be administered/provided; (c) Alternate evaluation services.

3. **Patient rights and responsibilities:** I am aware that I can ask a clinic representative for a copy of the BayCare Clinic Patient Rights and Responsibilities, or I can view the document in the clinic waiting area display.

4. **Confidentiality, harm and injury:** I understand that BayCare Clinic cannot ensure complete protection from all possible harm or self-injury. There are limits to the patient's confidentiality and privacy if the patient is in danger, or is judged a potential danger to self or others. Appropriate actions will be taken in response to threats of harm. Further, in accordance with State and Federal Law, information which becomes part of the electronic medical record may be shared with the patient's other medical providers for continuity of care purposes. Additional limits to confidentiality will be discussed by the psychologist as needed.

5. **Right to withdraw consent:** I understand I have the right to withdraw my consent for evaluation at any time.

6. **Expiration of consent:** Unless I have revoked my consent prior, this consent for evaluation will expire 12 months from the date of signature.

I have read and understand the above and consent to undergo an evaluation with BayCare Clinic Neuropsychology. I have had all of my questions answered, but am aware I can ask additional questions of my psychologist as they arise. A copy of this form shall be provided to the below Signatory upon request.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Parent / Legal Guardian (Required for any patient under 18 years of age)