childneuropsychologypc
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INFORMED CONSENT FOR TELEHEALTH CONSULTATION

I, _____ , parent/caregiver of _____
Parent Name(s) *Child Name*
have requested a neuropsychological Telehealth Consultation with Child Neuropsychology PC for the above-named child. I understand that:

_____ The Telehealth Consultation is a chance to examine my child's unique style and developmental status in the context of balancing need and risk. It uses a telehealth platform to gather and interpret data and provides consultation with the neuropsychologist who will recommend a course of action based on knowledge of child development, brain development and the identified challenges my child has meeting developmental expectations. The Telehealth Consultation is designed to help us access appropriate services and bridge us into relevant parenting strategies. It is not a Comprehensive Neuropsychological Evaluation nor is it psychotherapy.

_____ The Telehealth Consultation will consist of a detailed Parent Interview, completion of a developmental history form and standardized questionnaires about my child's behavior, emotions, social skills and learning style. When available and appropriate it will include interviews and/or use of standardized questionnaires with members of my child's therapeutic and education teams. Data will be reviewed with us in a telehealth Feedback Conference. The Telehealth Consultation will be billed an hourly rate hour with an *estimated cost range* of $1,200 - $1800. Additional services, such as added consultations/feedback appointments, school meetings, or in-person services will incur additional charges.

_____ In some circumstances a Telehealth Consultation will lead to more data collection in the form of additional neuropsychological services, such as testing. If so, all data and associated fees collected in the Telehealth Consultation will be applied to that service as long as it occurs within 6 months of the Telehealth Consultation. The additional services will be billed at the specified hourly rate up to, but not exceeding, services and fees associated with a Comprehensive Neuropsychological Evaluation.

_____ I understand that Child Neuropsychology PC **DOES NOT** bill nor accept insurance payments unless required by law and that cost of services provided by Child Neuropsychology PC are my sole responsibility. Child Neuropsychology PC will provide an itemized Statement of Services at the end of the Telehealth Consultation. Payment to Child Neuropsychology PC is expected at the time of service. Checks are preferred but payment by credit card can be accepted for an additional processing fee (currently 2.9%).

_____ Child Neuropsychology PC will provide a brief written report outlining the recommendations from the Telehealth Consultation. A copy of the report will remain in the Child Neuropsychology PC medical record. No other copies will be released except where required by law without the written permission of me, the parent/legal guardian, or of the patient if of legal age.

_____ Oregon law requires equal access to medical records by both biological parents unless otherwise decreed by formal legal judgment. I have legal authority to make healthcare decisions on my child's behalf. As applicable, I have informed Child Neuropsychology PC of the legal status of parent custody arrangements and have provided copies of legal documents needed to support my status as custodial parent and/or healthcare decision maker.

_____ I understand that information obtained during the Telehealth Consultation will remain private except as outlined within this consent form or in keeping with professional ethical standards, Child Neuropsychology PC policy, and applicable law. **There are specific instances in which information will not be kept confidential**. In these circumstances, information disclosed would be kept to the minimum that is necessary to achieve the purpose. Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as: To provide needed professional services; To obtain appropriate professional consultations; To obtain payment for services; or To protect the child/patient, psychologist, or others from harm. This includes instances where there is reason to believe that abuse of a child, elder, or person with developmental disabilities has occurred; or when a credible and specific threat of injury has been made.

The above information has been reviewed with me and I have had a chance to ask questions. I/we agree to proceed with the Stepped-Care Consultation/ Evaluation.

_____ _____ _____
Parent/Legal Guardian Parent/Legal Guardian Date

_____ _____
Witness Date