childneuropsychologypc
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CONSENT FOR IN-PERSON NEUROPSYCHOLOGICAL SERVICES

THERE ARE 3 SECTIONS TO THIS CONSENT. PLEASE READ EACH CAREFULLY AND SIGN/INITIAL AT THE HIGHLIGHTED PLACES. BE SURE TO SIGN, PRINT AND DATE YOUR FULL NAME AT THE END. THANKS SO MUCH.

I/We_____, parent/legal guardian of _____
Parent name(s) Child Name

RELEVANT TO IN-PERSON SERVICES DURING COVID-19

I/We understand that the threat of COVID-19 is ongoing throughout the United States. In so knowing, I have requested In-Person services at Child Neuropsychology PC on behalf of the above-named child. I understand that resumption of In-Person services at Child Neuropsychology PC is considered to have some risk but will be conducted under the published guidance from health authorities such as the Centers for Disease Control (CDC), the States of Oregon and Washington, and Multnomah County. I understand that provision of In-Person services is also considered with respect to individual, family, staff, and community health risks, local infection and hospitalization trends, ethical considerations and professional guidelines for neuropsychological practice under the COVID-19 pandemic. I understand that the decision to provide or suspend In-Person services will be made in consultation with me, but will remain the determination of the neuropsychologist or staff at Child Neuropsychology PC. I understand that appointments and/or services may change at any time.

I understand that the following protocols **MUST BE FOLLOWED WHILE RECEIVING IN-PERSON SERVICES**:

- Social distancing requirements must be followed, meaning that I and my child will maintain a three to six-foot distance from others while in offices, waiting rooms, and other areas.
- I and my child will be required to wear face coverings or masks while in the office.
- Hand sanitizer will be provided at the office entrance and must be used upon entering the office and after any cough, sneeze or touching of the face or mouth. Hand washing is available in a shared restroom that will be limited to at-need access only.
- There will be no physical contact with others in the office. There will be no use of common books, magazines, toys or other objects typically available in the waiting room. I agree to limit the number of personal items I or my child brings into the office.
- Generally, the waiting room will be available, but I may be asked to wait in my vehicle or outside the office while my child is working with the neuropsychologist. I am prepared to stay on the property and to be immediately available throughout my child's appointments.
- **I agree to complete the Pre-Appointment Screening Questionnaire** before *each* appointment and agree NOT TO PRESENT for In-Person services if I or my child have any symptom listed on that questionnaire such as fever, shortness of breath, coughing, loss of taste or smell, or other symptoms associated with COVID-19. I also agree NOT TO PRESENT for In-Person services if I or my child has been exposed to another person who is

showing signs of infection or has had a confirmed COVID-19 infection within the past two weeks. **There is no charge for rescheduled appointments related to illness or suspected exposure.**

- I agree to verify that my child is able to follow all safety protocols and agree to assume responsibility for my child's, and my own, compliance. I understand that an appointment will be suspended at the psychologist's discretion if safe behaviors cannot be maintained.
- I agree to inform Child Neuropsychology PC if my child or anyone in my household develops symptoms of COVID 19 within two weeks following any In-Person appointment at Child Neuropsychology PC.

I understand that the need to follow health and safety protocols under the COVID-19 pandemic may impact my child's experience and/or how he or she participates in evaluation activities in ways that we do not yet understand. For example, screening procedures and physical distancing measures might increase anxiety or distraction, or exaggerate underlying sensory sensitivities. Face coverings will interfere with features of nonverbal communication such monitoring facial expressions and will remove visual cues to language (e.g. the ability to watch mouth and lip movements). I understand that alterations in testing conditions and procedures will result in non-standard administration which could have an impact on my child's performance, interpretation of the findings, and/or the acceptance of scores by other stakeholders (i.e. schools). I understand that the evaluation report will document any variance from standard test administration due to COVID-19.

I understand that Child Neuropsychology PC may be encouraged to disclose my and my child's presence at Child Neuropsychology PC should there be a confirmed case of, or expected exposure to, COVID-19 by contact tracing authorities. I understand that any disclosure of will be limited to the minimum amount required by law.

I understand that Child Neuropsychology PC is committed to following published safety guidelines designed to mitigate risk of COVID-19 but cannot assure me that there is no risk to In-Person care. In pursuing In-Person care I assume risk of exposure for myself and my child, and although rare, I acknowledge that my child could develop Multisystem Inflammatory Syndrome (MIS-C) now found in a subset of children who have had, or were exposed to, someone ill with COVID-19. At at any point, I understand that I have the right to stop In-Person services and discuss other options of care with the psychologist at Child Neuropsychology PC.

After careful consideration, and with an opportunity to ask questions, my signature indicates my desire to pursue In-Person services for my child. I agree on behalf of myself and my child to follow safety protocols as outlined above or as communicated directly to me by staff.

_____ _____

Parent SIGNATURE (s) Date

RELEVANT TO THE NEUROPSYCHOLOGICAL EVALUATION

I/We have requested a Neuropsychological Evaluation to be conducted at Child Neuropsychology PC for our child. I/we understand:

_____ A neuropsychological evaluation is a chance to examine my child's unique style of thinking and learning. Beyond "scores," the evaluation uses norm referenced performance on formal tests, clinical observations, behavioral questionnaires, and knowledge of development and brain-behavior relationships to create a comprehensive picture of my child's unique pattern of strengths and weaknesses. As such, an evaluation is not therapy.

_____ The assessment consists of 6 hours of testing with the child, a Telemedicine pre-interview with the parents, completion of questionnaires and behavioral rating forms, a telephone interview with the teacher or therapist (when possible), an informing Telemedicine session with the parents to discuss the findings, and a comprehensive written report.

The cost of the evaluation is billed at $285/hr. and is typically ~$4500. Additional services provided beyond those listed above, such as an additional testing session, additional feedback sessions or school visits are charged at the hourly rate.

_____ Child Neuropsychology PC **DOES NOT** bill insurance, nor accept insurance payments unless required by law. Insurance coverage may be available to you through your policy. This is a contract between you and your insurer.

_____ You will receive a copy of the Neuropsychological Report at the conclusion of the evaluation. A copy 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 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. In the event of divorce or legal separation, you agree to inform Child Neuropsychology PC of the legal status of each parent and provide copies of legal documents of child custody issues, including restricted access to records if required. As clinically indicated, you understand that efforts will be made to include both parents in the evaluation process.

_____ You understand that information gleaned during the evaluation 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 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.
- To obtain payment for services.

RELEVANT TO TELEHEALTH SERVICES

I/we understand:

____ Video-conferencing differs from in-person experiences. There are potential benefits and risks of video-conferencing, such as issues around confidentiality. I understand that telepsychology is not appropriate in all circumstances and that my psychologist may recommend in-person services or an alternative to teleconferencing.

____ Video-conferencing requires the use of a webcam and microphone, with the possible backup of a smartphone or landline phone if internet connection is faulty. I will be given a link to the HIPAA compliant video-conferencing platform used by Child Neuropsychology PC. I agree to conduct my appointment in a quiet, private space that is free of distractions. I agree to discontinue use of other devices during sessions (e.g., cell phone, tablet, iPad, computer, etc.) and to sign in to the virtual waiting room at my designated appointment time.

____ I agree to use a secure internet connection rather than public/free Wi Fi for telehealth appointments. Confidentiality applies to telepsychology services. THERE WILL BE NO VIDEO OR AUDIO RECORDING by myself or by staff at Child Neuropsychology PC.

____ Test and therapeutic materials are copyrighted and CONFIDENTIALITY OF MATERIALS is extremely important. I agree not to copy, record, reproduce, publish or digitally save any material used during my appointments.

____ I understand that verification of my identity, location, and alternative contact information (e.g. phone number, email address) will be secured at the start of each appointment. In the event of technical problems, alternate contact information may be used to restart a session, or to reschedule if needed.

____ Some insurance carriers may not reimburse for telehealth appointments. I understand that I remain responsible for full payment of face-to-face and/or telehealth services rendered by psychologists at Child Neuropsychology PC.

FINAL SIGNATURE(S)

I have reviewed the above information and had an opportunity to ask questions. My signature below indicates my willingness to proceed with the Neuropsychological Evaluation under these terms.

_____	_____
Parent/Legal Guardian	**Parent/Legal Guardian**
_____	_____
PRINTED NAME	**PRINTED NAME**
_____	_____
Date	**Date**

Nancy Loss, Ph.D. Witness Date