Dana Chidekel, Ph.D.
A psychological corporation

Diplomate of the American Board of Pediatric Neuropsychology
Diplomate of the American Board of Professional Neuropsychology

INFORMED CONSENT FOR NEUROPSYCHOLOGICAL TESTING

USE THIS FORM ONLY IF YOUR CHILD
IS BEING FUNDED BY THE SCHOOL DISTRICT FOR AN IEE

Dr. Dana Chidekel, will administer neuropsychological and psychological tests to _____the child for whom you are responsible. If you have questions about testing, please discuss them with her. It is important that you, the adult legally responsible for the abovementioned child (henceforth, "my child"), understand this process. Initial each item below to indicate you have read it carefully and understand it:

_____1. I understand Dr. Chidekel will conduct an evaluation of my child consisting of standard neuropsychological tests. I understand that Dr. Chidekel will write a formal evaluation report based on the results of the testing.

_____2. I understand a copy of the report will be sent to the_____ School District. I authorize Dr. Chidekel to share the results with them.

_____3. I understand that if I or my child disclose(s) certain types of information to Dr. Chidekel, she may be required by law or permitted to communicate this information to other people. Information that can mandate or allow a breach of confidentiality include reports of child or elder physical/sexual/emotional abuse and threats my child makes to harm him/herself or harm another person.

_____4. I understand that Dr. Chidekel will need to get records from the school as part of this evaluation and will need to speak with my child's teacher(s). She is likely to make a visit to my child's classroom, if indicated. I consent to her doing so

_____5. I understand that as part of this evaluation, Dr. Chidekel may wish to get information about my child from other third parties whose names I provide, and that she will not do so without my written consent.

_____6. I understand that the school district will pay the fees for the evaluation, but they will not pay for charges incurred if I'm late for appointments. It will not pay for extra time necessary to complete an assessment that is necessitated by lateness; nor will it apply to time set aside for me that I cancel with less than 24 hours notice without good cause (e.g. illness). I agree to pay these charges directly, at her customary rate of $360.00 per hour.

CONSENT AGREEMENT: I have read, understood, and agreed to each of the previous items. I asked questions about any parts that caused concern or I did not understand. I understand and agree to the nature and purpose of this evaluation, how it will be reported, and to each of the points enumerated above.

_____

Signature Name Date

_____

Address and phone

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