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 TREATMENT DEPENDENT ADULT

Dr. Dana Chidekel, will be providing psychological services to your family member, _____ _____. You have agreed to be the responsible party. It is important that you understand several aspects of this process. Please initial each item below to indicate you have read it carefully and understand it:

_____1. I understand Dr. Chidekel will be consulting with my family member for psychotherapeutic services

_____2. I understand Dr. Chidekel's initial meeting(s) will be consultative. Consultation may require more than one meeting to permit her to understand issues comprehensively enough to recommend the best course of action. As part of the consultation, she may confer with others who have provided care, and she may review records that are provided as well. At the conclusion of the consultation, she will determine whether she is best suited to meet my family member's needs at this time. If not, she will recommend the best course of action to address the problems at hand.

_____3. I understand that the cost of her services for consultation and psychotherapy is $250/hr. This fee applies to time she spends with my family member in direct consultation, to time spent on the phone beyond what is necessary for scheduling, to time she spends reviewing records, and to time she spends consulting with the collateral sources. I understand she requires two working days/48 hours' notice for cancellation of appointments, or she charges for her time.

_____4. I agree to pay Dr. Chidekel's fee directly via a credit card that I will supply. I understand that I can place a cap on monthly fees beyond which Dr. Chidekel will not charge my card without my consent. Dr. Chidekel will provide me with monthly statements documenting the services she has provided.

_____5. I understand that if requested, Dr. Chidekel will provide my family member with paperwork necessary to file a claim with the insurance company, but she makes no guarantees about reimbursement. I understand that Dr. Chidekel will not pursue reimbursement from the insurance company directly.

_____6. I understand that my family member may not consent to have any information about him/her shared with any other party, including myself.

CONSENT AGREEMENT: I have read, understood, and agreed to each of the previous items. I have asked questions about any parts that caused the 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

_____

Email Telephone number

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