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 be consulting with you about performing a neuropsychological assessment of _____ _____, the child for whom you are responsible. It is important that you understand this process. Please initial each item below to indicate you understand it. If you have questions, please discuss them with Dr. Chidekel.

_____1. I understand Dr. Chidekel may conduct an evaluation of my child consisting of standard psychological and neuropsychological tests. I understand that Dr. Chidekel will write a report based on the results of the testing. I have the right to consent to this evaluation on my child's behalf.

_____2. I understand a copy of the report will be sent to the _____ School District. I authorize Dr. Chidekel to share 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. Types of 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 Dr. Chidekel may wish to speak with or get records from third parties whose names I provide as part of this evaluation, 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 (i.e. illness). I agree to pay these charges directly, at her customary rate of $480.00 per hour.

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