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 CONSULTATION AND TESTING - ADULT

I, Dr. Dana Chidekel, will be administering psychological and neuropsychological tests to you. It is important that you are aware of various 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 conduct an evaluation using standard psychological and neuropsychological tests. I understand that she will write a report based on results of the testing.

_____2. I understand that if I disclose 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 I make to harm myself or harm another person.

_____3. I understand Dr. Chidekel is performing an evaluation only and that she will recommend whatever services are indicated by the findings. When she is able, she will recommend specific professionals who provide those services. If this evaluation is being pursued for the purpose of seeking accommodations on the basis of disability or a determination of capacity for decision-making, she makes no guarantees about the findings of the assessment or the outcome of any petition I may file.

_____4. I understand that the cost of the evaluation is $9,500. I agree to pay this amount in full at the initial meeting. At the feedback session, Dr. Chidekel will provide me with paperwork necessary for me to file a claim with my insurance company, but she makes no guarantees about my ability to be reimbursed. I understand that that pursuing reimbursement from my insurance company is my responsibility.

_____5. I understand that the cost of the evaluation includes an initial one-hour consultation with me, up to nine hours test administration, up to one-hour record review and/or consultation with third parties (with my consent), a written report, and a one-hour feedback session. I understand that when she performs services beyond these, such as for consultation/medical records reviewed in excess of one hour, for travel to and from and attendance at meetings, for program observations, and for additional interview or feedback sessions, an additional fee of $725.00 per hour will apply. I understand she will not do additional work without my consent.

_____6. I understand that $725.00 per hour will be charged for extra time that must be scheduled to complete an assessment that is a function of my being late to appointments; for time set aside for me that I cancel with less than less than 48 business hours' notice; and retroactively for the time spent on an assessment that I terminate, for any reason, prior to its completion.

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 and phone

26500 Agoura Rd., Suite 102-872
Calabasas, CA 91302
Clinical & Forensic Neuropsychology
tel 818 705-4305
drdanac@drdanac.com