Pate and Culp Psychological Associates, LLC

**Patricia O’Connell, Ph.D.**

# 235 E. Ponce de Leon Ave.

Suite 200 Phone: (678) 984-4619

# Decatur, Georgia 30030 Fax: (404) 634-3482

**Consent to Evaluation**

I agree to undergo, (or I give consent for this person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to undergo) a psychological/neuropsychological evaluation. I understand that these services may include direct, face-to-face contact, interviewing, and/or testing. Services may also include the psychologist’s time required for the reviewing of records, consultations with other professionals, scoring and interpretation of results, and any other related activities in support of these evaluation services. The results of this evaluation will be communicated to me in a formal feedback session with Dr. O’Connell, unless other arrangements have been made (such as feedback with my referring or primary care physician).

A formal report of the evaluation will be made available to the referring healthcare professional and/or an appropriate healthcare professional of my choice. I will also receive a copy of my report from Dr. O’Connell. All test results, assessment data/information, and evaluation reports are maintained by Dr. O’Connell in accordance with state law and rules/guidelines of the American Psychological Association.

I will not hold Dr. O’Connell legally responsible for any events resulting from this evaluation or the records created by it. Information obtained from this assessment may only be used for the explicit purpose(s) stated below. If this evaluation is to be used in any way related to any legal proceeding, I agree to inform Dr. O’Connell at the time of the assessment or before. In the event this evaluation is to be used for any legal purpose, additional costs and payment arrangements may be incurred. Failure to immediately notify of my, or a designees, intent to use this evaluation for legal purposes will result in a breach of this contract and the doctor-client relationship otherwise implicit.

I understand that the purpose(s) of this evaluation is (are) to:

**Assess cognitive, emotional functioning**

I understand that although my health insurance or other resources may reimburse or repay me for some of these service fees, I am personally responsible for the full payment of services rendered. Specific services and their estimated costs will be discussed with me in advance. Full payment of the estimated cost is expected at the time of the evaluation or before, unless other arrangements are made.

I understand that I may withdraw my consent to this evaluation at any time during the evaluation. I understand that I may withdraw my consent to transfer formal evaluation results by means of a written letter. However, I also understand that my withdrawal will not be retroactive (that is, withdrawn consent will not apply to testing and information transfer that has already taken place).

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Signature of Client or Responsible Party Date