Christopher Royer, Psy.D.

Comprehensive Neuropsychology Services

CONSENT FOR EVALUATION

I do hereby give consent to Dr. Christopher Royer, or his designee, to provide a neuropsychological and/or a psychological evaluation.

Evaluation

I understand that during this evaluation my cognitive (thinking) skills may be tested, and I may be asked about how I am feeling (my emotional state). Information from this evaluation can be used to provide me, and my doctor or other professional with information about my abilities and any difficulties I have in these areas. I understand that I may ask questions at any time about the expected goals of this evaluation. I understand that feedback about the results of this evaluation is available upon my request. I understand that I will receive a report of the results of this evaluation.

Payment

I understand that payment is required for all services rendered. I understand that if I have chosen a third party (private insurance company, HMO, Worker's Compensation, Auto Insurance, attorney etc.) to provide payment for this evaluation, the terms of these payment arrangements may require that psychological information, including psychological records (such as my report), be released to the payer for the purposes of justifying payment for the evaluation. I understand that I am responsible for any balance not covered by an insurance company or third party. I understand that if I pay for this evaluation, that payment in full is due on the day of the evaluation.

Confidentiality

I understand that confidential information is protected by law. As such, I understand that any information about this evaluation will not be provided to anyone without my <u>informed written consent</u>. This includes friends and family who may be interested in my care. By signing this form, I understand that a copy of my report and other notes will be sent to the doctor or professional who referred me. I also understand that some insurance companies may require that my family physician be notified that I am having this evaluation.

I understand that there are exceptions to confidentiality when Dr. Royer or his designee may be required to waive confidentiality and release information to a doctor, professional or legal agency. These include the following:

- A life-threatening emergency in which I would be unable to provide important information about myself.
- If I am judged to be a danger to myself or anyone else.
- If there is any concern about current or past abuse or neglect of a child.
- If there is a court order to release information about me.

Business Hours:

I understand that the office is open Monday through Thursday from 9am to 4:30pm and on Friday by appointment only. I understand that if I need emergency care that I should call 911 or my nearest crisis unit. I understand that the office has a 24-hour answering service.

1150 Lancaster Blvd • Suite 101 • Mechanicsburg, PA 17055
Phone 717-697-7260 • Fax 717-697-7262

Completion of Forms

I understand that in the case that you would like Dr. Royer to complete disability paperwork or other forms, there is a charge of $20 for each form payable when the form is given to Dr. Royer.

Consent

I agree and understand the terms herein, and do hereby give my consent for Dr. Royer or his designee to perform my evaluation. I understand that if I am seen in this office for any treatment following this evaluation, I will need to complete a separate consent form.

Name: ___________________________________

Signature (age 14 and up): ___________________________________ **Date:** _____/_____/_____

Signature of Parent, Guardian or Legal Representative (if under 18 or incapacitated)

____

Staff Witness Signature: ___________________________________

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