Neuropsychology Associates, Inc.
Child & Adolescent Neuropsychology
P.O. Box 603102
Providence, RI 02906
(401) 455-0221

CONSENT TO EVALUATE/TREAT

Patient's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Parent/Guardian SS#: _____

Address: _____ Telephone #: _____

City/State/Zip: _____

1. I, the undersigned, am the patient, parent and/or legal guardian of the above-named minor patient.

2. In the capacity of parent and/or legal guardian, I consent to examination, assessment, and treatment protocols of said minor by Neuropsychology Associates, Inc., as deemed medically appropriate.

3. As the parent and/or legal guardian, I am responsible for maintaining satisfactory financial status with Neuropsychology Associates, Inc. I shall notify the office at least 24 hours in advance of a scheduled appointment should rescheduling be necessary, or incur, and be responsible for payment of, a failure to keep appointment fee. If my insurance company fails to pay for services rendered, I will be responsible for payment.

4. This consent to treat said minor shall remain in effect until:

   - Treatment protocols are concluded and/or minor is discharged from the services of Neuropsychology Associates, Inc.

   - Neuropsychology Associates, Inc. receives written notification from the parent and/or legal guardian regarding the intent to terminate treatment.

   - Neuropsychology Associates, Inc. receives written notification from the minor regarding the intent to terminate treatment.

_____ _____
Signature of Minor Patient Date

_____ _____
Signature of Parent and/or Legal Guardian Date

_____ _____
Printed Name of Parent and/or Legal Guardian Relationship to Minor

_____ _____
Signature of Witness Date