NeuroPsychology Associates, Inc.

Child, Adolescent, and Adult Neuropsychologists

Consent to Evaluate/Treat

Patient's Name: _____ Date of Birth: _____

Street Address: _____ City, State, ZIP: _____

Telephone #: _____

1. I consent to examination, assessment, and treatment protocols by Neuropsychology Associates, Inc., as deemed medically appropriate.

2. 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 or cancellation be necessary, or incur and be responsible for payment of a fee for failure to keep an appointment.
   - If my insurance company fails to pay for services rendered, I will be responsible for payment.
   - I agree to have a credit card number kept on file with Neuropsychology Associates, Inc., which will be charged for any billed copayments, deductibles, and other out-of-pocket expenses at least 30 days overdue.

3. This consent to treat shall remain in effect until:

   - Treatment protocols are concluded and/or I am discharged from the services of Neuropsychology Associates, Inc.
   - Neuropsychology Associates, Inc. receives written notification from me regarding the intent to terminate treatment.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

_____ _____

Signature of Witness Date