1 Washington Street, Suite 4144

Dover, New Hampshire 03820

Telephone: 603-740-6371

Fax 603.742.1414

REGISTRATION INFORMATION

(PLEASE PRINT)

Date:_____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Gender Identity:_____ Preferred Pronouns:_____

Date of Birth_____

Home Phone_____ Cell Phone_____

Email address_____

How were you referred to this office?_____

_____

Consent for Psychological/Neuropsychological Evaluation

Your signature below indicates that you have reviewed and agree with the following:

Nature of the evaluation:

- I understand that I am being seen for a psychological or neuropsychological evaluation. The evaluation will include some/all of the following components: record review, clinical interview, and testing with various measures of attention, motivation, motor and sensory abilities, language, spatial skills, problem solving, memory, and emotional/personality functioning.
- I understand that the purpose of this evaluation is to provide information about me for my service provider who has requested the evaluation, in order to assist in diagnosis and treatment.
- Dr. Griffin's interview questions may touch on personal and private matters that could cause me emotional discomfort and/or revive painful memories. Even though some of the interview questions may not appear at first glance to have a direct connection with the issue at hand, I will cooperate to the best of my ability. I understand that, although I am expected to give honest and accurate answers, I am free to refuse to answer any question and/or to terminate the evaluation whenever I wish.
- The material from interview and psychological/neuropsychological testing will result in the generation of a report that will provide information related to my diagnosis and treatment. The report generated by Dr. Griffin will be sent to the individual who referred me for this evaluation and Dr. Griffin may also discuss the results of the evaluation with that person.

Billing for services:

- If I have insurance, Dr. Griffin's office will bill my insurance company for the time spent in evaluation, interpretation, report writing, and communication of the results. I understand that I am expected to promptly pay all required copays and deductibles, as billed. If my insurance company refuses payment for the evaluation, I understand that I am ultimately responsible for paying for the costs of the assessment.
- Time spent completing forms/writing letters and/or speaking to schools, employers, attorneys, or other non-health care providers is not billable to insurance. I understand that I will be billed directly for any such services that are requested of Dr. Griffin.

Limits to confidentiality:

- I understand that, while the information shared by me during this evaluation is confidential, Dr. Griffin is required by law to notify authorities in the following cases: 1) if she knows of or suspects that a child or elder adult is being abused and 2) if she has reason to believe that I may harm others or myself. In addition, if I become involved in a legal action in which I claim mental health issues related to the legal action, Dr. Griffin may be required to release mental health records upon receipt of a court order.

I have reviewed, understood and agreed to the terms of this evaluation_____ (print name)

Signature::_____ Date: _____

NORTHEAST EVALUATION SPECIALISTS
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Dover, New Hampshire 03820
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Fax 603.742.1414

Acknowledgement of Receipt of Information

I acknowledge that I have been given the opportunity to review this office's privacy policies (*Notice of your NES Provider's Policies and Practices to Protect the Privacy of your Health Information*) and the *Mental Health Bill of Rights*.

I understand copies can be made available to me upon request.

Signature:_____Date:_____