

Arrowhead Psychological & Behavioral Sciences, LLC

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Consent for Psychological/Neuropsychological Evaluation

I understand that the purpose of this evaluation is to provide information about me for an independent examination, civil, or criminal case and not used for treatment purposes. Consequently no doctor-patient relationship will be or is intended to be formed nor will any advice or responses to inquiries about diagnoses or treatment matters be provided.

Dr. Roche's questions will touch on personal and private matters that could revive painful memories. I recognize that Dr. Roche has no intention of causing any personal discomfort but that she is simply carrying out her professional task associated with this evaluation. Even though some of the subject under discussion may not appear at first glance to have a direct connection with this 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 I choose or to terminate the evaluation whenever I wish. It is understood that what ever I state during this evaluation may later be the subject of inquiry. Dr. Roche is required to notify authorities if she knows of or suspects that a child is abused or if she has reason to believe that I may harm others or myself.

It is understood that if a report is developed as a result of this evaluation it will be forwarded to a representative of the organization requesting the exam, an attorney or his/her designate. Disclosure of any aspect of that report will be the responsibility of the recipient of the report or his/her designate.

The terms of this evaluation have been reviewed, understood and agreed to by me.

Sign: _____ Date: _____

(Please Print Name)

Address: _____

(Street)

(City & State)

Phone: _____