Consent to Evaluation and/or Treatment

(Minor Under Age 13)

Patient Information

Patient Name:

Date of Birth:

Consent Statement

I am the parent or legal representative of the above-named minor. I voluntarily consent to outpatient psychological and/or neuropsychological examination, evaluation, and, if applicable, treatment provided by Pediatric Neuropsychology Associates PLLC.

This consent authorizes professional services conducted by a licensed mental health professional for the purpose of assessment and/or treatment. I understand that neuropsychological evaluation is distinct from psychotherapy or ongoing treatment, and that additional consent may be required for services beyond evaluation.

Neuropsychological services provided by Pediatric Neuropsychology Associates PLLC are clinical in nature and are not intended for forensic, legal, or custody-related purposes unless explicitly agreed upon in writing.

Acknowledgements

I acknowledge that I have been informed of the following:

- The nature, purpose, and procedures of the proposed psychological and/or neuropsychological evaluation and/or treatment
- The potential benefits and risks of these services
- That meaningful results require the child's reasonable cooperation and participation, and that limited cooperation, fatigue, emotional distress, or behavioral dysregulation may affect the validity or completeness of findings
- Reasonable alternatives, including the option of no evaluation or treatment
- Patient confidentiality and its limitations under Florida law, including mandatory reporting of suspected abuse or neglect and situations involving risk of serious harm to the patient or others
- Fees and payment policies, including service fees, payment methods, cancellation or no-show policies, and potential additional charges
- The name and contact information of the mental health professional providing services
- The potential involvement of third parties (e.g., insurance companies, referring professionals, schools, or legal entities), with consent or as permitted or required by law (including court orders, situations involving risk of harm, abuse, or neglect)
- The voluntary nature of services and my right to refuse or discontinue services

Written reports and records are clinical documents prepared for the parent or legal representative. Release or sharing of records with third parties occurs only with written authorization, except as required by law.

I confirm that I have received, reviewed, and understand the information provided regarding these services. I have had the opportunity to ask questions, and all questions were answered to my satisfaction. I understand that no guarantees have been made regarding outcomes or results.

I hereby give informed and voluntary consent to the psychological evaluation and/or treatment described above for the minor named above. I understand that consent for voluntary outpatient mental health treatment may be revoked at any time by notifying the mental health professional responsible for the patient's care, except to the extent services have already been provided.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgment (for Minors or Individuals Lacking Legal Capacity)

By signing below, I acknowledge that I have received and reviewed this Consent to Evaluation and/or Treatment. I understand the nature and purpose of the evaluation, what the evaluation involves, potential risks and limitations, alternatives to evaluation, and my right to ask questions or withdraw consent.

I confirm that I am the parent or legal representative of the child named below and that I have the legal authority to provide consent on the child's behalf. I voluntarily consent to evaluation and/or treatment services as described above.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed form will be retained in the patient's health records.

For Office Use Only

Date Received:

Received By:

Staff Role:

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: