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Psychological and Neuropsychological Testing

Psychological or neuropsychological testing typically involves a three-part process. The first part involves an intake evaluation lasting about 40 minutes in which the patient meets with the psychologist to discuss reason for referral, symptoms, background information, and details about the testing process. Any minor child will have to be accompanied by a legal guardian during the intake evaluation. In the case of shared guardianship, both guardians should be present, to provide the background information. If this is not possible, then both guardians have to provide written consent giving permission to complete evaluation without being present. Behavior rating forms may be given to the patient or guardian(s) during the intake evaluation and need to be returned prior to the feedback session. In some circumstances, if the requested forms are not returned and are needed to complete the evaluation, the feedback appointment will have to be rescheduled. The next session is to complete the testing. This will be an appointment that lasts for 2-3 hours and is performed by a trained test technician. The last appointment is a feedback session lasting about 25-30 minutes which typically occurs about two weeks after the test session to discuss the results, diagnostic formulation, and treatment recommendations. During this session, minor children do not attend, and it occurs between the guardian(s) and the psychologist.

Consent for Treatment

Your signature below indicates that you understand the testing process and procedures and your responsibilities. By signing, you agree that you understand the policies and fees of the practice, you consent to receive treatment, you agree to pay all charges, and that your questions have been answered to your satisfaction. Thank you.

Signed_____ Date_____
Responsible Party

Parent or Legal Guardian Consent (Must Be Signed If Child is Under the Age of 18)

I certify that I have legal custody, or I am the legal guardian of and have medical decision-making rights for _____ (Child's Name). My signature below grants permission for Dr. Kimberly S. Adams, PsyD ABPP-CN to offer professional evaluation and treatment to my child for whom I am legally responsible.

Signed_____ Date_____
Parent or Legal Guardian

Signed_____ Date_____
Parent or Legal Guardian