Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #5, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673
Jenniferbadgley@mainlineneuropsych.com

Consent for Evaluation and Treatment

Patient's Name (please print):_____DOB:_____

Parent/Guardian Name:_____

Relationship to Client:_____

Authorization for Services:

I,_____hereby give full consent for the above named patient and/or myself to receive services at Main Line Neuropsychology, PLLC, until I notify Main Line Neuropsychology, PLLC otherwise or until Main Line Neuropsychology, PLLC determines that services are no longer appropriate or will not be provided. I further certify that I have the legal authority to authorize and consent to treatments and evaluations at Main Line Neuropsychology, PLLC as parent, guardian, or managing conservator.

Description of Services:

I understand that the purpose of evaluations conducted by professionals at Main Line Neuropsychology, PLLC is to provide information about the patient and/or myself related to diagnosis and treatment plans for the patient and/or myself. The evaluation may include an interview, review of previous reports/records, and standardized testing and data collection. Testing may be completed in one session, or over several sessions and days. The testing schedule will be determined by Main Line Neuropsychology, PLLC, the patient, and/or myself. In some cases a separate appointment may need to be scheduled to discuss the results of the evaluation.

I understand that the purpose of treatment (e.g., psychotherapy, counseling, parent consultation, etc.) is to help me and/or the patient address areas of concern or difficulties in behavioral, cognitive, emotional, social, or academic functioning. I agree to work with the professional to develop treatment goals, and understand that it is my responsibility to notify the treating professional of any changes in my treatment goals.

Cost and Payment Procedures:

I understand that payment for services (i.e., copays, deductibles, coinsurance, self-pay amounts) is due before or at the beginning of the patient's and/or my appointment, unless other arrangements have been discussed prior to the appointment. If charges are being submitted to a third-party payer (e.g., insurance company), I understand that I will still be responsible for payment for services (i.e., copays, deductibles, coinsurance, self-pay amount) at the beginning of the session. I will be reimbursed for any overpayment when the claim pays Main Line Neuropsychology, PLLC/Jennifer Badgley, PhD. If the claim pays, and I underpaid and still owe a patient responsibility, I will be responsible for paying that amount to Main Line Neuropsychology, PLLC/Jennifer Badgley, PhD. I understand that I will be responsible in full for payment of any procedures or office visits that are not covered by the third-party payer, and for any claims for which the third-party payer denies payment or does not reimburse Main Line Neuropsychology, PLLC/Jennifer Badgley, PhD, for any reason. If my insurance company has not paid my cognitive evaluation claims (interview and cognitive testing) before my feedback session, I understand that I am responsible for full payment of all services (interview, cognitive testing, feedback) before or at the beginning of the feedback session. I understand that I will not receive any written reports until my balance for services is paid in full by me and my insurance company. I understand that my account may be forwarded to a third party collections agency if I do not pay for any charges or fees that I incur, in accordance with Main Line Neuropsychology, PLLC policy and any applicable laws. I understand that academic/educational testing, educational-based reports, school observations, private school entrance evaluations, educationally based consultations, and school meetings are not covered by insurance.

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I understand that I will be charged a $50 fee for each and any standard (1-hour) appointment, and a $200 fee for each and any testing (2 or more hours) appointment for which I or the patient fail to show or that I cancel without 24 hours advance notice. I understand that these fees will not be submitted as claims to insurance, and that I am responsible for paying them.

____ (Initials)

Confidentiality:

I understand that any information I provide to Main Line Neuropsychology, PLLC staff/professionals is confidential and generally will not be released to others without my written consent. I understand that state and/or federal law might require Main Line Neuropsychology, PLLC staff/professionals to disclose confidential information without my consent in one or more of the following situations (but not limited to the following): 1) if Main Line Neuropsychology, PLLC staff/professionals believe a child is the victim of abuse or neglect 2) if the patient is believed to be a danger to self or others 3) if information is disclosed about the physical or sexual abuse of a minor, person who is disabled, or an elder person 4) if a suit is filed by me and/or the patient against Main Line Neuropsychology, PLLC staff/professionals for breach of duty and 5) if a court order, legal proceeding, statue, or regulation requires disclosure.

I understand that I will not receive a copy of my and/or the patient's medical record without the approval of my and/or the patient's psychologist, or other authorized Main Line Neuropsychology, PLLC professional staff. I understand that email communication with anyone at Main Line Neuropsychology, PLLC and faxing are not considered a secure form of communication and the confidentiality of such communication cannot be guaranteed.

I understand that a third-party payer (e.g., insurance company) and third-party billing service (Therapist Solutions) will have access to any of my and/or the patient's personal health information that is necessary for the submission, certification, processing, or reimbursement of any claims that occur as a result of my obtaining services at Main Line Neuropsychology, PLLC.

____ (Initials)

Consent:

My signature on this form verifies that I have had the opportunity to ask questions regarding Main Line Neuropsychology, PLLC services, procedures, policies, consultation/evaluation and therapeutic techniques and that my questions were answered to my satisfaction by the staff and/or professionals of Main Line Neuropsychology, PLLC. My signature on this consent form verifies that I agree to the terms and conditions set forth in this form. I voluntarily give my consent for evaluation and treatment with the understanding that I have the right to withdraw my consent for evaluations and/or treatment at any time. I understand that if I withdraw my consent for evaluations and/or treatment I will still be responsible for payment for any procedures and office visits that were conducted prior to said withdrawal.

My signature on this consent form verifies that I understand that this evaluation and/or treatment is being conducted for clinical and/or academic purposes and is not being conducted for forensic or expert testimony purposes in a legal proceeding. I understand that Dr. Badgley does not participate in mediation, arbitration, litigation, or legal proceedings.

_____ _____
Name of Patient (Please print) Date of Birth of Patient

_____ _____
Signature of Parent/Conservator/Guardian/Patient(if 18 or older) Date

_____ _____
Printed Name of Parent/Conservator/Guardian/Patient(if 18 or older) Relationship to Patient