Neuropsychological Services of Oregon, LLC

231 SW Scalehouse Loop, Suite 203
Bend, OR 97702

Phone: 541-306-6456
Fax: 541-647-1580

Statement of Informed Consent For
Psychological/Neuropsychological Evaluation

Nature and Purpose of Evaluation:

I understand that I am being seen for a neuropsychological/psychological evaluation. The evaluation will include an interview, record review, and testing with various measures of attention, motivation, language, spatial skills, problem solving, memory, intellectual functioning, and emotional or personality functioning. Additionally, with consent from me, Dr. Kreiling may interview other individuals who may have helpful information regarding my history and/or current circumstances. I may request further information about any of these procedures.

I understand that the purpose of this evaluation is to provide information about me for my physician or other health care provider who has requested the evaluation in order to assist in their diagnosis and treatment of me. Information obtained during neuropsychological and psychological evaluations is often used to assist with diagnostic clarification and treatment planning; however, I understand that there is no guarantee that the evaluation will have this result. The material from the interview(s) and psychological/neuropsychological testing will result in the generation of a report that will provide information related to diagnosis and treatment of me. The report generated by Dr. Kreiling will be sent to my physician or other health care provider, and Dr. Kreiling may discuss the results with them. If desired by me, or my referring provider, Dr. Kreiling will also discuss the results with me and any others which I so designate Dr. Kreiling to do so. If this evaluation is being covered or partially covered by my insurance Dr. Kreiling may be required to provide the insurance company with a report as well.

Dr. Kreiling's questions will touch on personal and private matters that could cause me emotional discomfort and revive painful memories. I recognized that Dr. Kreiling 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 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 I choose or to terminate the evaluation whenever I wish. I understand that if I terminate the evaluation prior to completion the referral question(s) may not be answered and diagnosis or treatment recommendations may not be made.

Dr. Kreiling:

Dr. Kreiling is a licensed psychologist in the State of Oregon (license number 2524) and the State of Pennsylvania (license number PS016811, currently inactive status).

Her education and training includes:

- Bachelor's Degree in Psychology from the University of Oregon in Eugene, Oregon (2003)
- Master and Doctoral Degrees in Clinical Psychology with a specialization in Neuropsychology from Pacific University in Forest Grove, Oregon (2005 and 2008)
- Pre-doctoral internship in Clinical Psychology with specialization in Neuropsychology at Eastern Virginia Medical School in Norfolk, Virginia (2007-2008)
- Post-doctoral fellowship in Neuropsychology and Brain Imaging Research at Dartmouth-Hitchcock Medical School in Lebanon, New Hampshire (2008-2010)

Dr. Kreiling was employed as a Clinical Neuropsychologist with Geisinger Health System in Pennsylvania (2010 to 2014) prior to her returning to Oregon to establish Neuropsychological Services of

Oregon, LLC. She specializes in the evaluation, diagnosis, and treatment of adults with a variety of behavioral health conditions.

Risks and Benefits:

I understand that testing can take several hours to complete and for some individuals these assessments can cause fatigue, headaches, frustration, and anxiousness. I also understand that another entity may use information from the evaluation report to make decisions regarding me, decisions which may or may not be desired by me. I understand that benefits may include feeling less distressed, finding solutions to problems, and learning how to work with my individual strengths and weaknesses.

Limits on Confidentiality:

I understand that in most cases all information (i.e., interview notes, test protocols, test reports, progress notes, etc.) is kept confidential. This information is kept in the medical and/or psychological record and cannot be released without written consent, *except* under the following circumstances in which Dr. Kreiling may be required or allowed by law to report to certain state agencies or otherwise release information to another party *without* my consent:

- If she has reasonable cause to believe that a child under the age of 18 has been or is being abused or neglected.
- If she has reasonable cause to believe a person with developmental disability, chronic mental illness, or an elderly person has been or is being abused, neglected, or exploited.
- If you make a specific threat of violence to another person or to society.
- If she believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself, she may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.
- If a government agency is requesting the information for health oversight activities, she may be required to provide it for them. For example, if a complaint is filed against Dr. Kreiling with the Oregon Board of Psychologist Examiners, the Board has the authority to subpoena confidential mental health information relevant to the complaint.
- If a patient files a complaint or lawsuit against Dr. Kreiling, she may disclose relevant information regarding that patient in order to defend herself.
- If Dr. Kreiling finds that it would be helpful to consult with other health and mental health professionals about a case. During her consultation every effort would be made to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. Dr. Kreiling will note all consultations in your Clinical Record.
- Dr. Kreiling employs administrative staff. In most cases, she needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Dr. Kreiling has contracts with an accountant and a health information telecommunications network to do her electronic billing with insurance companies. As required by HIPAA, she has formal business associate contracts with these businesses, in which each has promised to maintain the confidentiality of the data except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers or to collect overdue fees are discussed in the "Statement of Financial Responsibility."
- If you file a worker's compensation claim, she may disclose information from your record as authorized by worker's compensation laws.

Meetings:

I understand that the evaluation may consist of an interview, cognitive and/or emotional testing, and a feedback appointment to review the results of the evaluation. Each of these steps in the process of evaluation may occur on the same day or different days. I understand that testing sessions often take several hours to complete. A feedback appointment may be scheduled one to two weeks after the completion of testing.

Cancellation Policy:

I understand that a minimum of 48 hours' notice is required for cancelation of appointments, as staff set aside a substantial block of time for the evaluation. **Cancellation of my appointment can be made by calling Neuropsychological Services of Oregon, LLC at 541-306-6456. If I do not cancel my appointment at least 48 hours prior to my scheduled appointment time, I may be charged a minimum of $150 up to the full amount of time which was reserved for the appointment at the rates posted in the office of Neuropsychological Services of Oregon, LLC.**

Use of Technician:

I understand that Dr. Kreiling may delegate administration and scoring of tests to a trained technician.

Billing, Payments, and Professional Fees:

I have been provided with the "Statement of Financial Responsibility," which I understand details my responsibilities regarding billing and payment for services. I understand that Dr. Kreiling's professional fees are available at the office of Neuropsychological Services of Oregon, LLC, and they may be provided to me upon request. I acknowledge that if I choose to terminate the evaluation process, I will still be responsible for all fees associated with the treatment that has been provided, as well as any additional time spent scoring and interpreting the tests that have been completed. Additionally, I am responsible for report writing time regardless of Dr. Kreiling's ability to clarify diagnosis and/or provide treatment recommendations due to limited information that resulted from my decision to terminate the evaluation.

Professional Records:

I understand that the laws and standards of Dr. Kreiling's profession require that she keep Protected Health Information about me in my Clinical Record. I may examine and/or receive a copy of my Clinical Record, if I request it in writing. Raw test data may only be released to persons qualified to interpret such information to avoid misuse of the testing services. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, Dr. Kreiling recommends that I initially review them in her presence, or have them forwarded to another psychologist qualified to interpret neuropsychological and psychological test results so I can discuss the contents. I understand that Dr. Kreiling charges a copying fee per page. Based on Oregon law, the charge for copies is $0.50 per page for the first 50 pages and $0.25 per page for each additional page. Shipping costs may also be added to the fee. Actual costs of preparing an explanation or summary of protected health information may also be charged.

Contacting Dr. Kreiling:

I understand that due to Dr. Kreiling's work schedule, she is often not immediately available by telephone. When Dr. Kreiling is unavailable her telephone is answered by an answering voicemail. I understand that I may leave her a message and Dr. Kreiling will return my call as soon as possible. I understand that if I am unable to reach Dr. Kreiling and I feel that I cannot wait for her to return my call, I will contact my family physician or the nearest emergency room and ask for the psychiatrist on call. I understand that if I am experiencing a medical emergency I should call 911 or go to the nearest emergency room. The policy on "Electronic Communications" has been provided to me. I understand that in the unlikely event that Dr. Kreiling is seriously injured or ill and unable to complete/continue my treatment, I may be contacted by a licensed

colleague of hers. This licensed psychologist would assist me as needed and/or provide me with an appropriate referral.

Effort and Motivation:

I am aware that this evaluation is aimed at identifying patterns of cognitive strengths and weaknesses and guide diagnosis and treatment recommendations. I understand that it is important for me to perform to the best of my ability and answer questions honestly. I understand that if my test performance suggests that I am not putting forth my best effort or I am exaggerating symptoms, this can invalidate my test results leading to inconclusive findings which will impact diagnosis and treatment recommendations. Effort, motivation, and symptom exaggeration may be assessed and commented upon in the final report. If you do not think you can put forth your best effort during testing, please inform Dr. Kreiling immediately.

Recording:

I understand and agree that given the confidential nature of the evaluation, no portion of the evaluation, including but not limited to the intake interview, testing session(s), feedback session, or follow up treatment session(s), shall be audio or video recorded by any party.

Questions or Concerns:

By signing below, I will acknowledge that I have read and understood the above information. I also acknowledge that all of my questions have been answered. I have been informed that if at any time I have further questions about my care I am encouraged to ask Dr. Kreiling.

My signature below indicates that I, and/or my personal representative, acknowledge that I have read and understood the above information or that the examiner clearly explained in understandable terms the above information and that consent is given for the evaluation. I understand that this evaluation is not intended for forensic use.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient
(or Legal Guardian/Representative) Date

I, the Provider, have discussed the issues above with the patient (and/or his or her guardian or other representative) and they indicated understanding and consent.

_____ _____

Signature of Provider Date