Emanuel Troiani, Psy.D.
Licensed Clinical Psychologist, Neuropsychologist
Certified School Psychologist

1018 N. Bethlehem Pike, Suite A-1
Lower Gwynedd, PA 19002

700 Horizon Circle, Suite 101
Chalfont, PA 18914
(215) 233-5688

Patient Consent for Neuropsychological Evaluation

Evaluation Process:

The goal of this evaluation is to help you, your treating providers, and qualified third parties gain a better understanding of your relative cognitive strengths and weaknesses, any subtle or remarkable changes relative to prior functioning, specific diagnostic considerations, and treatment recommendations.

The tests employed are designed to evaluate brain-behavior relationships and include measures of memory, language, attention, abstract reasoning, visual organization, and visual-motor skills. True-false and self-report questionnaires will be included. A comprehensive clinical interview will also be conducted. In addition, supplementary records from hospitals, treating physicians, psychologists, schools, as well as interviews with designated family/friends may be obtained with your consent.

The interview and testing process itself typically lasts approximately 6 to 8 hours total, but we will split this up over 2 to 3 office visits, more if needed. You will be offered breaks as necessary. Once the tests are administered, the data analyzed, and relevant records reviewed, the results will be incorporated into a written report for your referring physician that explains the test findings, diagnostic considerations, and recommendations. A post-test consultation will be scheduled to discuss the results with you.

Typical Costs:

A typical evaluation is comprehensive and includes not only the time spent directly with the patient, but also time spent reviewing records, scoring the tests administered, interpreting the results, and writing reports. The direct testing time is approximately 6 to 8 hours. Reviewing records, scoring tests, interpreting test results, writing the report, and meeting for a feedback session will likely add 6 to 8 hours to the direct contact time. Additional information on fees is available upon request.

Financial Policies, Payment and Assignment of Benefits:

***Returned checks will result in a fee of $35.00 billed to the patient.**

Although we are in-network with many insurance plans, the terms of individual policies can vary significantly, even within a particular insurance program. It is, therefore, ultimately your responsibility to contact your insurance company to understand exactly what your insurance covers and the requirements specific to your policy (co-pays, deductibles, referrals, limitations of benefits, etc.).

By signing this consent, you agree that you understand the following: The patient (or parent/legal guardian, if the patient is a minor) is responsible for any unpaid balance not covered by their insurance. In the event of an unpaid balance, dates of service and demographic information may be shared for collection. You acknowledge that it is your responsibility to know your insurance coverage details. If you need help understanding your insurance coverage and benefits, it is your responsibility to contact the office of Dr. Troiani, or your insurance provider, for further explanation.

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By signing below, I am authorizing assignment of insurance/third party benefits, and payment/collection of benefits, to Dr. Emanuel Troiani; payment for services is thereby directed to him. I understand that Dr. Troiani may need to release my medical record data to the insurer or a third-party billing/collections agency in order to obtain payment for this evaluation.

Confidentiality:

The records concerning this evaluation will be retained by Dr. Troiani and will be kept confidential. No information will be released (other than to designated referring third parties where applicable) without prior written consent, except in the case of medical emergency, to secure payment for treatment from health insurance plans or other third part payment system, or as permitted by law. Under the following circumstances, the law requires or permits that information be disclosed:

1. When there is reasonable suspicion of child abuse or neglect, or evidence of elder abuse.

2. When a person presents an imminent and/or potentially serious danger to self or others.

3. In the event of certain court orders, including subpoenas for judicial arbitration or mediation.

Release of Information:

By signing the acknowledgement and consent form below, you agree to the release of both oral and written information to the referring party and/or your primary physician. In order to release information pertaining to your case to individuals other than the referring party, you must sign a separate written consent form authorizing the release of the requested material to the designated party. Please refer to the "HIPPA Notice of Privacy Practices" provided to you in your intake paperwork packet for more information.

Office and Scheduling Policies:

CHALFONT OFFICE PATIENTS: Due to the high demand (and low availability) of appointments at our Chalfont office location, patients who cancel less than 48 Business Hours prior to their appointment will *NOT* be rescheduled at Chalfont. Also, patients who do not show up for their appointments (no-show) at this location will *NOT* be rescheduled at Chalfont. There will be no exceptions.

Patients' appointments are required to occur in a particular order. Therefore, it is important to try and keep your original appointments and avoid rescheduling, if possible. If a patient cancels their first and/or second appointment(s), all remaining appointments will also be rescheduled to the first available appointments. Due to our busy, and often full, calendar this may result in appointment dates being rescheduled several months out and some of the original testing, performed at the Intake, may have to be repeated and additional fees may occur.

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Acknowledgement and Consent:

By signing this form, I grant consent to be evaluated by Dr. Troiani. I acknowledge that I, or my legal designee, have read and understood the above, that any questions I had were satisfactorily clarified and understood, and that I consent to the limitations of confidentiality. I understand that I have the right to review or revoke this consent at any time either verbally or in writing.

Patient Signature (if minor, write "minor") _____ **Date**_____

Parent/Guardian Signature #1 (for minor patient) _____ **Date**_____

FOR PATIENTS UNDER 14 YEARS OF AGE (Required):

Per PA State Law, we must obtain the signatures of both Parents/Legal Guardians to administer testing to children under 14 years of age. If second parent is deceased, check this box: ☐

Parent/Guardian Signature #2 (for minor patient) _____ **Date**_____

This authorization is in compliance with the Pennsylvania Mental Health Procedures Act, section 7100.111.3, the Pennsylvanian Drug and Alcohol Abuse Control Act and Act 52 of the Pennsylvania State Psychology Board.