CAROL V. ANDERSON Ph.D.™

Licensed Psychologist
Board-Certified in Clinical Neuropsychology

101 S. Park Ave. Suite 215 ● Idaho Falls, ID 83402 ● 208-522-3404

Registration Form

Name____ Male____ Female____

Today's Date ____

Mailing Address ____
____
____

Phone: Home____________________________ Work/Cell________________________________

Age: ________ Date of Birth: ____________________ Birthplace: _______________________________

Referral Source: _______________________________

Current Concerns: ____
____
____
____
____
____
____
____
____
____

Current Medications: ____
____
____
____
____

Employer/School Information:
Occupation: ____

Employer: ____

Highest Grade Completed: _________

Current School (if a student):____

CAROL V. ANDERSON Ph.D.™

TESTING CONSENT FORM

This form will provide information about my services and about your rights and responsibilities as a client. Please be sure to discuss any questions with Dr. Carol Anderson. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

TESTING:
Through the use of a variety of standard psychological and/or neuropsychological tests, I will attempt to answer the questions that have brought you here for this assessment. These questions generally concern learning disabilities, behavioral problems, developmental delays, academic functioning, personality functioning or problems resulting from brain injury or trauma. Throughout the assessment you have the right to inquire about the nature or purpose of all procedures. You have the right to withdraw from the testing session at any time. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational intake interview followed by the administration of standardized neuropsychological tests. Although it is sometimes possible to complete the testing process in one sitting, it is most common for people to be scheduled for two half-day evaluation sessions to complete an assessment battery. Once testing is completed and the data have been analyzed, a copy of the report will be sent to the referring party.

EFFORT:
I understand that I am to give my best effort throughout the course of this evaluation. This does not mean that I have to get every answer correct, as no one is expected or able to do so. However, I do have the responsibility to give my best effort, and I affirm that I will do so. Part of this evaluation will address the accuracy of my responses, as well as the effort that I exert on test items. An accurate and valid understanding of my neuropsychological status requires that my test results reflect the best effort, performances, and self-reported information that I am capable of providing. If any factor would prevent me, at any point in this evaluation, from putting forth my best effort and best possible test performances or responding, I will notify Dr. Anderson or any other examiner (if applicable). I understand that information that is incomplete, inaccurate, or misleading may affect the interpretation of my test findings or opinions rendered in my behalf.

CONFIDENTIALITY & PRODUCTION OF RECORDS:
The information obtained in this evaluation is confidential and will not be released to any person or organization without your written consent. The only exceptions to this policy are rare situations in which we are required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if it is judged that you are in danger of harming yourself or another individual; or 3) if your records or Dr. Anderson's testimony are sought by court order. We will attempt to notify you before any action is taken and would limit disclosure of confidential information to the minimum required to comply with the law.

Raw data (e.g. test protocols and/or other copyrighted or trademarked materials) will not be provided to attorneys or clients, unless Dr. Anderson has been court-ordered to provide these items, and with distribution/disposal stipulations in place. Dr. Anderson will provide raw data to qualified Clinical Neuropsychologists, upon request. Two weeks notice is required for raw data production.

NATURE OF THIS EXAMINATION (IME):
This is an independent examination (IME) requested by a third party who is financially responsible for the cost of the examination. There are differences between an independent examination and a usual clinical examination. I understand there is no patient – doctor (neuropsychologist) relationship. This is a public procedure in the sense that the usual confidentiality between patient and neuropsychologist does not apply. In addition, the results of this examination, as summarized and contained in a report, are the property of the requesting/paying party. I will not be provided directly with results, with an interpretation of results, or with diagnostic opinions or therapeutic recommendations. Such information may be included in a report sent to the requesting/paying party and must be obtained directly from that party in the usual and customary manner.

AGREEMENT:
I have read the above material, and I fully understand my rights and obligations as a client. I understand the limits of confidentiality of test results. Further, I understand that the interpretation of assessment findings is based on my specific test results and Dr. Anderson's clinical judgments. I understand that I may obtain a second opinion at my discretion. I freely agree to this assessment.

Name of Client Date

Signature Date
(Client or parent/legal guardian)

Witnessed By: Date

CAROL V. ANDERSON Ph.D.™

Consent to Release Medical Information

Name of Patient : __________________________ Date of Birth: _________________

Information To Be Released: Communication with Dr. Anderson
Neuropsychological/Psychological Testing Report
Other: _________________________

Designated Person from whom information is being requested:

Name: Carol V. Anderson, Ph.D., ABPP-CN
Address: 3729 Woodking Dr. Suite 1
Idaho Falls, ID 83404

Phone: (208) 522-3404

Name of Physician, Health Care Provider, Hospital and/or Other Designated Person authorized to communicate and/or receive records specified above:

Name:

Address:

Phone:

Fax: ____

Purpose of Disclosure: ____________________________

Statement of Consent:

The undersigned does hereby authorize and consent to the disclosure of any and all information, records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to the condition, care, confinement and treatment of the above-named patient, by the above-named individual or entity or their representative, to the above-named physician or physicians,

health care provider, hospital, and/or other designated person(s), and does consent to the inspection and duplication of the indicated records by the same.

The undersigned further agrees to waive any and all privileges granted under the provision of law which may either directly or indirectly pertain to this disclosure as hereby authorized.

Signature:____

Date:____