DAVID S. GEISER, PH.D, P.A.
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License # PY5048

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(NEURO)PSYCHOLOGICAL SERVICES AGREEMENT AND CONSENT

I do hereby seek and consent to take part in the treatment by the (neuro)psychologist named below. I understand that my best effort and full cooperation in the evaluation conducted by the (neuro)psychologist will result in the most accurate information to help guide my medical treatment and/or develop an appropriate psychotherapeutic treatment plan. I understand that no promises have been made to me as to the results of my evaluation or treatment or of any specific procedures provided by this (neuro)psychologist. I am aware that I may stop my evaluation or treatment with this (neuro)psychologist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I understand that all discussions with and all information provided to the psychologist are confidential and can only be released to others with my expressed written consent. I have read and understand the nature and scope of legal exceptions to the privilege of confidentiality, and I have received the "*Notice of Psychologists' Policies and Practices*" regarding my rights under the HIPAA Privacy Act.

I have received and agree to the terms of my responsibility for payment of services, as described in the *Guarantee of Payment and Assignment of Insurance Benefits* document. I know that I must call to cancel an appointment at least 48 business hours before the time of the appointment. I am aware that an agent of my insurance company or other third-party payer may be given only the minimal information required about the type(s), costs(s), date(s), and provider(s) of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the (neuro)psychologist may stop my evaluation or treatment.

My signature below shows that I understand and agree with all of these statements and that I allow David S. Geiser, Ph.D., P.A. to bill my insurance company or other designated guarantor.

_____ _____ _____
Signature of client (or person acting for client) **Date** **Relationship to client (if Necessary)**

_____
Printed Name

_____ _____
Witness **Date**

I, the psychologist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Psychologist **Date**

___Copy accepted by client ____Copy kept by Psychologist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.