NeuroBehavioral Associates

Vincent P. Culotta, Ph.D., ABPN • Melissa Blackwell, Psy. D. • Kirk Griffith, Ph.D., MBA

DATE ______________________

CONSENT FOR TREATMENT OF AN ADULT

I, ________________________ authorize NeuroBehavioral Associates to provide me with an evaluation. I also give permission for my primary therapist or primary care physician to consult with NeuroBehavioral Associates to insure quality care of my treatment.

I understand that all data interpretation, diagnosis, and report preparation are provided by a licensed psychologist. Psychological associates, supervised by a licensed psychologist, may administer standardized assessment measures.

____

PATIENT (or Guardian if applicable)

* *

RETURNED CHECK CHARGE

All returned checks are subject to a $25.00 returned check charge. All payments must then be made in cash or by money order.

____

PATIENT (or Guardian if applicable)