

# NEUROBEHAVIORAL ASSOCIATES

*Specializing in Attention, Learning, and Neurodevelopmental Differences*

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Neuropsychological Consultation & Evaluation  
Forensic Evaluation  
Referral Services  
Educational Consultation

DATE: \_\_\_\_\_

## **CONSENT FOR TREATMENT OF A MINOR (if applicable)**

As a custodial parent, I authorize NeuroBehavioral Associates to provide an evaluation and treatment of my minor child, \_\_\_\_\_.

I give permission to NeuroBehavioral Associates to use de-identified test data in research studies. **YES/NO (circle one)**

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)

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## **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)

