

# **AARON N. JUNI, PH.D.**

CLINICAL NEUROPSYCHOLOGIST

## **NEUROPSYCHOLOGY CENTER OF MARYLAND**

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SPECIALIZING IN CLINICAL NEUROPSYCHOLOGY

## **CLINICAL CONSENT FORM**

### **Patient Rights**

I understand that I, or someone in my care, is being evaluated and/or treated by Dr. Aaron N. Juni, a clinical neuropsychologist with specialized training and expertise in understanding brain function and behavior. The terms detailed within this agreement outline the nature and scope of provided services, obligations and limitations. I am entering into this agreement willingly and recognize that I have the right to terminate this relationship at any time by informing Dr. Juni in writing.

### **Services**

A typical evaluation includes review of medical records, clinical interview, collateral interview, testing with various measures of cognitive abilities, psychological functioning and behavior, and a follow-up feedback session. I understand that Dr. Juni's ability to provide useful insight and recommendations is highly dependent upon my willingness to be forthcoming in responses to questions, and exert maximum effort on all examination procedures. I understand a typical evaluation is comprehensive and includes not only face-face time, but also time spent reviewing records, contacting collateral information sources, scoring tests, interpreting test results, and writing a report. This typically requires an additional 4-8 hours of work above the direct contact time.

Upon completion of the evaluation, findings and recommendations are typically discussed in a follow-up feedback session. A written report may also be generated that is sent to the patient, referring health care provider(s), and/or others designated in writing on the release of information form.

I agree to inform Dr. Juni if services are being requested in a litigation context and recognize that clinical services may be insufficient to satisfy forensic or medicolegal requirements.

### **Confidentiality**

Records concerning the evaluation will be maintained in accordance with APA guidelines and Maryland State Law. No information about will be related to any person or institution without your written consent, except as permitted by law under the following conditions: 1) Subpoena or court order by a judge or court of law; 2) reported abuse or molestation of a child, elder or dependent adult; or revelation that such incidents have occurred by others; 3) indication of intent to harm or kill self or specific others; or 4) authorized request for release of records by client's health insurance company. Please note that Dr. Juni has no means to protect the confidentiality of information after it has been released to an insurance company or other third party.

### **Fees and Financial Responsibilities**

Our office does not currently participate with any third-party health insurance plans and operates strictly on a fee-for-service model. Fees will be discussed and provided in writing prior to service

provision and are expected to be paid **in-full** on the date of service. The office will not submit insurance claims directly, nor accept assigned payment for services. Rather, it is the client's responsibility to arrange for out-of-network reimbursement with their insurer and our office will provide the client with requested paperwork.

Clinical services are billed at \$350 per hour. This rate also applies to time spent in consultation, reviewing records, scoring tests, drafting written reports, and completing paperwork. 50% of the full cost for evaluation services is due during the first appointment, with the remainder of the fees required upon the final testing date. Please note that tests will not be scored, and reports will not be written, until payment has been received in full.

In addition to clinical rates, a \$75 materials fee is required at the first testing appointment to cover the cost of assessment protocols and scoring programs.

Cancelled appointments with less than 48-hour notice, as well as late arrivals (> 15 minutes) are subject to a \$250 fee per scheduled hour.

Please read and check each of the following items:

**I bear full financial responsibility for all services rendered by Dr. Juni as described in the above sections. I agree to pay \$350 per hour of service in a timely manner on the day of the appointment.**

**I understand that a \$250 hourly fee is charged for cancelled/no-show appointments and late arrivals > 15 minutes with less than 48-hour advance notice. I authorize Dr. Juni to charge my credit card accordingly for these fees.**

### **Acknowledging Signatures**

My signature below confirms that I have read and understood all the terms and conditions described within this document and agree to be bound by them for 12 months following the date of signature.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date