EVALUATION CENTER FOR LEARNING
Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441-4433

Patient's Name_____ Date of Birth _____

CONSENT FOR ASSESSMENT

- I understand that by signing this consent for treatment form, I have: read the Office Policies (included in a separate document), received answers to any questions that I have related to the assessment process, and agreed to the terms of the Office Policies.
- I understand that promises have not been made about the results of this assessment and that the results may differ from expectations.
- I understand that I may stop the assessment and revoke my consent in writing at any time; however, if I choose to do this, I will be responsible for payment for services rendered until that time.
- I understand that I must call to cancel my/my child's appointment at least 24 hours before the time of the appointment. If I do not cancel the appointment and do not come, I can be charged 50% of the hourly fee for that appointment.
- I understand that the clinicians at the ECFL do not participate in any insurance plans. As such, I am responsible for any information provided to the insurance company. I will be provided with CPT code(s) for Dr. Edidin's services, which can be submitted to insurance, if I choose.
- I understand that I am responsible for payment for all services rendered. Dr. Edidin charges an hourly rate. A partial payment of $2000 is due at the initial appointment with the balance due at the parent feedback.
- I understand that reports will not be finalized and provided to you until payment for testing has been received in full, unless previous arrangements have been made with Dr. Edidin.
- I understand that phone calls over 15 minutes will be charged at our hourly consultation rate.
- I understand that, if my account is not paid within 60 days of the feedback session, my credit card will be charged for the remaining balance and any fees that are incurred to process the payment with a credit card. My credit card information will remain on file until my balance is paid in full at which time it will be destroyed.
- I understand that the results of this assessment may be shared with my child's primary care physician unless I indicate otherwise below (initial). It also may be shared with referring or treating clinicians unless I explicitly tell the clinicians otherwise.
  _____ I do not want ECFL to communicate with my child's primary care physician.
- By signing this form, I indicate that I am the legal guardian of the patient named above, and I am authorized to provide informed consent for treatment.
- I consent/assent to take part in the assessment by the clinician(s) at the ECFL.

_____ _____
Signature of Patient or Recipient of Service (if over 12 years old) Date

_____ _____
Signature of Parent or Guardian (if under 18 years old) Date

_____ _____
Printed Name of Parent of Guardian (if under 18 years old) Relationship

ELECTRONIC COMMUNICATION

Please initial next to the specific information that you would like to receive electronically. There is risk involved in electronic communication; consequently, we ask that you do not provide sensitive information in an email. Your initials indicate that you agree to assume all risks involved in electronic communications.

_____ Scheduling

_____ Other Communication

_____ Final Reports (encrypted)

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HIPAA ACKNOWLEDGEMENT

This form serves as acknowledgement that you have been informed of your rights under The Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, a copy of which has been given to you, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of this session. Your signature below serves as acknowledgement that you have received a copy of the HIPAA Notice Form (included in a separate document) described above.

_____ _____
(Parent or Student 18 years old or older) (Date)