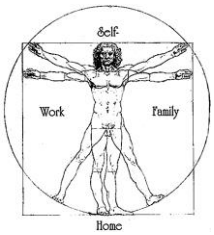
4785 Hayes Road
Madison, WI 53704
608-242-7160
Fax 608-242-7153



COUNSELING RESOURCES
NEUROPSYCHOLOGICAL ASSOCIATES, LLC
Informed Consent to Treatment

Patient:_____ DOB:_____

I have been provided information regarding the following treatment:
- ☐ Interviews
- ☐ Psychotherapy
- ☐ Neurobehavioral/Neuropsychological/Psychological Evaluation (Testing)
- ☐ Cognitive Training
- ☐ Other_____

I understand I have the right to information concerning the following:
1) the benefits and purpose of treatment;
2) the manner in which the treatment is to be administered;
3) alternative treatment modes;
4) the probable consequences of not receiving proper treatment.

Treatment is being provided:
- ☐ at the patient's request
- ☐ at the request of (name & relationship) _____

Treatment is to be provided at:
- ☐ Counseling Resources Neuropsychological Associates
- ☐ Dodge County Human Services, 199 Home Rd., Juneau, WI 53039
- ☐ Other_____

My informed consent will remain in effect for 12 months from the date this consent is signed or until case closure. I understand that I may withdraw my informed consent at any time in writing. My signature on this form indicates my consent to the above treatment. A copy of this document is considered to be as valid as the original.

Patient Signature (if age 14 or above*): _____ **Date** _____

If patient lacks sole legal authority to sign for him/herself (e.g., if patient is under age 18, or over 18 and legal guardianship is in place) complete the following:

Patient is unable to sign because: _____

Authority of Personal Representative: Parent ☐ Health Care POA ☐ Guardian ☐ Other ☐

Personal Representative Name and Address: _____

Personal Representative Signature:_____**Date**_____

(*Note: If patient is age 14 to17 years, both the personal representative and adolescent signatures are required for authorization.)