Developmental Discoveries
NEUROPSYCHOLOGY

3030 Harbor Lane N Suite 205 Plymouth, MN 55447 (763) 330-2730 developmental-discoveries.com

When parents are not married or are divorced but both have legal custody, we must get consent from each parent to provide services. The parent who called to schedule is sent a consent to sign. The other parent must sign and return this document in order for us to provide services. The parent signing this form is welcome to contact us to ask questions, join parent appointments, or provide information as part of the evaluation.

Consent to treat

I consent to and authorize the health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my wellbeing. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of diagnosis or success or outcomes of any examination, treatment, diagnosis, or test, performed at Developmental Discoveries.

Psychological services include consultation services regarding behavioral, developmental, or emotional concerns; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which has been shown to have benefits in the reduction of feelings of distress, increased satisfaction in the interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees or assurances of what you will experience.

I understand that I have the right and responsibility to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

I understand and acknowledge that Developmental Discoveries may record medical and other information related to my treatment in electronic format and that such information will be used for payment purposes and to support healthcare operations.

I understand, acknowledge and consent to the release of my personal health information for the purposes of treatment, payment and healthcare operations and as may otherwise be permitted by law.

I specifically consent to the release by Developmental Discoveries of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to: 1) my treating physicians and other healthcare providers and 2) any private health insurance plan, other governmental insurance program or other third-party payor identified to obtain payment for the treatment and services provided to me.

Providers are not directly available by phone. A message may be left with the front desk staff and will be returned by the psychologist. Every effort to return your call within a reasonable time is made during business hours. In the event of an emergency, contact your family physician, call 911, or proceed to the nearest emergency room.

_________________________	_________________________
Signature	Date
_________________________	_________________________
Printed Name	Relationship to Child