Island Neuropsychology, LLC
Pediatric Neuropsychology
2113 Middle Street, Suite 301
Sullivan's Island, SC 29482
(843) 885-8087

CONSENT TO EVALUATE/TREAT

Patient's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Parent/Guardian SS#: _____

Address: _____ Telephone #: _____

City/State/Zip: _____

1. I, the undersigned, am the patient, parent and/or legal guardian of the above-named minor patient.

2. In the capacity of parent and/or legal guardian, I consent to examination, assessment, and treatment protocols of said minor by Island Neuropsychology, LLC as deemed medically appropriate.

3. As the parent and/or legal guardian, I am responsible for maintaining satisfactory financial status with Island Neuropsychology, LLC. I shall notify the office at least 24 hours in advance of a scheduled appointment should rescheduling be necessary, or incur, and be responsible for payment of, a failure to keep appointment fee. I understand that insurance is not accepted and that submitting for insurance reimbursement is my responsibility. I accept that payment will be charged the day of the appointment.

4. This consent to treat said minor shall remain in effect until:
   - Treatment protocols are concluded and/or minor is discharged from the services of Island Neuropsychology, LLC.
   - Island Neuropsychology, LLC receives written notification from the parent and/or legal guardian regarding the intent to terminate treatment.
   - Island Neuropsychology, LLC receives written notification from the minor regarding the intent to terminate treatment.

_____ _____
Signature of Minor Patient Date

_____ _____
Signature of Parent and/or Legal Guardian Date

_____ _____
Printed Name of Parent and/or Legal Guardian Relationship to Minor

_____ _____
Signature of Witness Date