CENTER FOR HEALTH SOLUTIONS, PLLC
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CONSENT TO TESTING & CONTRACT FOR SPINAL CORD STIMULATOR SURGERY EVALAUTON

- I am aware that a pre-operative psychological evaluation is required. This evaluation will consist of an extended clinical interview and psychological assessment.
- I consent to take part in the evaluation for the purpose of accurate diagnosis and treatment planning. I understand that it is in my best interest to actively participate in the evaluation and to follow the treatment recommendations that result.
- I understand that it is extremely important that I am completely honest with Dr. Lisson so that she can make an informed decision and provide me the optimal level of care as I go through this process. I understand that Dr. Lisson wants to ensure my success with surgery.
- I understand that I have the right to refuse or discontinue the evaluation at any time. However, doing so could impede effective diagnosis and treatment planning.
- I understand that my psychological evaluation report will be released to my referring physician and to my insurance company for further review, and that they will ultimately determine whether or not I am approved for surgery.
- I understand that Dr. Lisson and my referring physician will be sharing treatment recommendations. I am aware that the result of this evaluation is a recommendation regarding my appropriateness for surgery and the level of support I may need in order to optimize my success with the surgery.
- I understand that neither raw test data nor the psychological report will be released directly to me. I am aware that if I desire feedback or an interpretation of my testing, I will need to schedule an additional session with Dr. Lisson.
- I understand that there is no guarantee that any particular outcome will result from the evaluation.
- I understand that there is a fee for comprehensive testing and evaluation and that I may be responsible for the cost of the evaluation, if my insurance does not cover the full contracted amount. The evaluation includes a clinical interview, psychological testing, interpretation of the testing, collaboration with other providers, and the preparation of the psychological report. I understand that it is possible that my insurance plan will not consider this evaluation medically necessary, though my plan may still require the procedure for surgery. I understand that the psychological report will not be submitted to the referring physician until full payment is received.

If you have any questions or concerns, please address them with Dr. Lisson before signing this. My signature indicates that I understand and agree to all of the above.

Client/ Representative Signature: Date

Print Name: Date

I have addressed the client's concerns and/or questions. The client appears full competent to give informed consent.

Dr. Lisson signature: Date