GRANDIS
Evaluation Center
Home Trust Bank Plaza 1011 Tunnel Rd Ste 220 Asheville, NC 28805
P: 828.299.7451 F: 828.299.7454 Email: info@GECtesting.com

Client Consent

Client Name_____ Date of Birth_____

Medicaid Number_____ Copy given to Consumer____ Copy Denied___

I hereby consent to assessment services provided by the Grandis Evaluation Center, PC. I understand that I may refuse any or all services at anytime. Services may include, but are not limited to developmental, mental health, behavior, cognitive, achievement, adaptive and personality assessment, consultation and/or outpatient therapy. I understand that a written report will be generated from an assessment and this report will be sent to the referring agency given the proper release of Protected Health Information is in order. I understand that requests by the undersigned to inspect the report or receive a paper copy of this report will be made through the referral source. If I am involved in a court proceeding and a request is made for information about professional services covered under this consent, such information is considered privileged and cannot be disclosed without further authorization. This privileged does not apply if I am being evaluated for a 3rd party or the evaluation is court ordered. (In the case of an emergency I give permission to obtain any emergency services required. I understand that I will be financially responsible for such care).

_____ _____

Client/Legally Responsible Person's Signature Date

Client Rights: I have received and read a copy of the Professional Services Agreement from the Grandis Evaluation Center, PC. I understand its content regarding Client's Rights and Responsibilities and my questions about this Professional Services Agreement have been answered.

_____ _____

Client's/Legally Responsible Person's Signature Date

HIPAA Notice of Receipt of Privacy Practices

- I acknowledge that I have received and read a copy of the Notice of Privacy Practices for services provided by the Grandis Evaluation Center, PC.
- I understand that the Notice of Privacy Practices discusses how my protected health information (PHI) may be used and/or disclosed and my rights with respect to my PHI.
- I may obtain an additional copy of this Notice at any time. I understand that the terms of this Notice may be changed in the future and I may request a copy of the new Notice.

_____ _____

Client's/Legally Responsible Person's Signature Date

_____ _____

Witness for above (3) Signatures