Main Office (Hanover):
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Chambersburg Office:
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Chambersburg, PA 17201
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INFORMED CONSENT AND AGREEMENT FOR OFFICE OF VOCATIONAL REHABILITATION (OVR) EVALUATION SERVICES

The OVR will cover all of the fees for this evaluation. **I acknowledge that because the OVR provides full payment for this evaluation, they will receive all results of this evaluation, as well as verbal communication with *Cognitive Health Solutions, LLC* (CHS) providers regarding my case. They will either disclose a copy of these results directly to the patient or provide CHS this permission. Results will not be given directly to the patient without the consent of the OVR.** CHS will not release these results to any other party without a separate signed authorization to release form *as well as permission granted by the OVR*. There is no guarantee of a particular outcome. You have the right to refuse to participate based on professional ethics, state law, and federal law. CHS also has the right to refuse or withdraw services for appropriate professional cause including refusal or lack of cooperation with services deemed necessary for the evaluation. You are responsible for consequences that result from refusal or lack of cooperation.

My signature signifies agreement and acceptance of the terms stated, including my rights regarding privacy. Furthermore, it grants the providers at CHS permission to work with me or my child and affirms voluntary consent to the services being pursued.

This agreement becomes part of the patient's record.

Patient Name (print)	**Patient Signature (if 18+)**	**Date**

***If joint legal custody exists, both parents/guardians must sign**

Mother/Legal Guardian Name (print)	**Mother/Legal Guardian Signature**	**Date**
Father/Legal Guardian Name (print)	**Father/Legal Guardian Signature**	**Date**