

# CHAPTER 1

## The Five W's

*Who are neuropsychologists? What do they do?  
Where and when do they do it? Why are they used?  
This chapter will provide answers to all these questions.*

### The Who

Neuropsychologists are doctoral-level professionals with either a doctorate of philosophy in psychology (Ph.D.) or a doctorate in psychology (Psy.D.). Neuropsychologists obtain their doctorate degree through 4–6 years of graduate school, typically in a clinical psychology program. They see patients, take courses, and conduct research. After graduate school, they are admitted to an internship where they primarily see patients for one year.

Upon completing internship, most neuropsychologists will secure additional training at the post-doctoral level. Typically, this is a two-year fellowship specifically tailored for neuropsychology training and incorporates additional clinical work and training. Upon completion of this fellowship, neuropsychologists become board eligible – in other words, they can apply for the American Board of

Clinical Neuropsychology (ABCN) board. Neuropsychologists with the letters ABPP-CN after their Ph.D. have successfully completed their board certification. That said, there are many neuropsychologists who are not board certified, including some who have been practicing for years. Even today, not all newly trained neuropsychologists are board certified – some because they see little need to do so, others because they have not had the time to start the process. By finding someone who meets the board eligible criteria, you will at least ensure that they meet the standards required to practice clinical neuropsychology (see footnote 1).

When choosing a neuropsychologist, other factors to consider include:

***Reputation:*** Word of mouth is perhaps the most powerful way to obtain a reliable name. If another family worked with a practitioner with satisfactory results, this is a positive sign this practitioner can work with you as well.

***Availability:*** Some practitioners are extremely busy and schedule patients months ahead. How responsive are they and how timely are they in returning emails and phone calls?

***Cost:*** Assessment costs range widely, in part related to reputation and experience, but also keep in mind the services that are being offered. As described in the *what* section of this chapter, there are different report types and some might be more suitable for your child than others.

***Insurance:*** Some practitioners take insurance, for which they are compensated less than for private cases. Because of this, insurance cases may offer briefer evaluations and reports than do private cases.

***Location:*** Practitioners who work near your zip code will know relevant counselors, educational therapists, and other resources. They may have a closer relationship with your school.

***Experience:*** Training does not end after fellowship. Practitioners who have been working for years will be more experienced. They

may be more familiar with the problems your child has, and be more connected with the community. On the other hand, those just starting out might be more available and charge less.

**Methods:** No two neuropsychologists work alike. Some break up assessments over 2–3 days while others allow for one-day assessments. Some regularly schedule school visits while others do not. See how many days the assessment will take, where the neuropsychologist is willing to go, and who he or she is willing to speak with (e.g. teachers, other professionals). Find out how long their reports take to be written, how soon can feedback be scheduled, and if the neuropsychologist will remain available after the assessment for follow-up consultation.

**Training:** It's important that anyone who does a complete neuropsychological assessment be a doctoral-level practitioner, preferably board eligible if not board certified. However, there are other types of practitioners that offer services that might be appropriate for your child's needs and who are qualified to do some assessments.

**Educational/School Psychologist:** This is doctoral-level degree (Ph.D or Ed.D) that focuses on learning in the school environment. School psychologists conduct assessments, usually focused on identifying learning disabilities, and coordinate students' care in the school environment. Often, a school psychologist will conduct the initial testing of a child and refer out to a neuropsychologist if deemed necessary.

**Clinical/Counseling Psychologist:** Many clinical psychologists are general practitioners of psychology while others choose to specialize in areas such as behavioral health, pediatric medicine, or drug addiction. All psychologists are trained to provide assessments and therapy and some psychologists elect to conduct assessments of children. These assessments might not be as comprehensive as a neuropsychological assessment, but depending on the question being answered, they might suffice.

***Child Psychiatrist:*** Psychiatrists are medically trained doctors and therefore can prescribe medication, which psychologists usually cannot. As medical doctors, they are often the first or second practitioner to work with a child dealing with the mental effects of a medical illness. They often refer to neuropsychologists when there is a question about cognition – for example in cases involving ADHD or learning disabilities.

***Licensed Master's Degrees:*** There are several practitioners who are eligible to practice at the Master's level (that is, two-year post-bachelor's degree). Licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT), and licensed professional counselors (LPC) are all trained to provide therapeutic services to individuals and couples.. Those who specialize in children are qualified to see your child. A board-certified behavioral analyst (BCBA) is another master's level degree that has specialty training in the behavioral sciences. Many BCBA practitioners specialize in treating children with autistic spectrum disorders.

Typically, anyone who uses the title “psychologist” has a doctoral level degree. However, in the state of California, there is a master's level degree called “Licensed educational psychologist” (LEP). Something to keep in mind is that most government and educational agencies do not recognize diagnoses provided by a master's level practitioner. Therefore, if you are seeking a diagnosis for your child it is recommended that you establish the practitioner's credentials and ensure that he or she has the training equivalent to a doctorate (Ph.D., Psy.D. or Ed.D.).

***Cautionary Groups:*** The above degrees are established degrees for mental health practice. However, mental health has yet to establish the same level of training standards that medicine has. You would never encounter a nurse who refers to him or herself as a “doctor” and yet, the equivalent of this does unfortunately happen in the mental health world. I will describe groups that may warrant some caution

in approaching, particularly if you know little about the individual's reputation.

First, be careful of individuals who call themselves “doctors” yet do not have a doctorate in a field that allows them to practice. There are known cases of individuals with Ph.Ds in primarily academic fields, such as biology, experimental psychology, or even English or philosophy, who then go on to obtain a master's degree that allows them to practice. By mixing their practicing degree with their Ph.D., they might refer to themselves as “Dr. Smith” or such. This is actually an unethical practice as the Ph.D. came from a non-licensable degree, although it can be difficult to catch. Make sure that their Ph.D. is in the field that they are practicing.

Second, while the term psychologist is generally a protected term that only doctoral-level professionals can use (LEP being a unique exception), the term therapist is not. Someone who has never been to college, or even graduated high school, can refer to themselves as a “therapist” or “counselor” or “life coach” at any time in their lives. They might even have degrees and certifications granted by “boards” that will print up a degree if you pay their fee. Please note that not all practitioners who choose this path are incompetent; simply that there was minimal oversight in ensuring their competency. I would be especially wary of individuals who conduct assessments without an advanced degree.

## **The What**

What exactly goes into an evaluation? While no two neuropsychologists work alike, there are common methods that are shared. Neuropsychology always involves the assessment of brain functioning. Such assessments examine cognition, behavior, and emotional functioning. Most assessments begin with an interview with at least one primary guardian and involves taking a comprehensive history

of the child. Along with the initial interview, follow-up interviews with other adults involved in the child's life, including teachers and professionals are often conducted. There are often behavior and emotional questionnaires that will be distributed to you and other adults. These questionnaires generally ask for your report on how the child is functioning in one or more areas.

After the first interview, testing usually begins. The tests are varied in presentation but generally come in pencil-and-paper form or are sometimes administered on the computer. Some are designed to mimic core academic tests of reading, writing, and mathematics while others are more abstract. Children might have to arrange blocks (either with their hands or using mental imagery), find patterns, define words, memorize lists or images, and engage in other puzzle-like activities. Many of these tests resemble games and can be fun for children. Testing is usually conducted between 1–4 sessions. The exact number of sessions and hours varies depending on the age of the child, the nature of the problem, the neuropsychologist's style, and the referral question, but the usual length is between 4 and 8 hours.

When all is said and done, you will have a report detailing the results of your child's evaluation. This report has a number of uses. Along with clarifying diagnoses and establishing treatment plans, reports can provide detailed insights on how your child processes information. Is he a visual learner? Does she learn quickly but respond impulsively to questions? Does he have significant testing anxiety that interferes with concentration? Does she process auditory information fine but does not use any strategies to remember that information? These are all questions that the report can address.

The report can also be shared with other professionals. In the public school setting, reports are often required to set up Individualized Education Programs (IEPs) and 504 plans. Independent schools often request reports to set up their own system of accommodations for the child. Reports can be submitted to testing centers to request extended time, additional rest breaks, and other accommodations for

standardized tests such as the SAT and GRE. Doctors can use reports to adjust their treatment plans, including medication management. Speech, occupational, and physical therapists can see what exactly their therapies have targeted and what remains a growth edge. Counselors can get additional insight on the child's psychological functioning. This report serves as a broad and yet in-depth examination of your child's functioning that is applicable on many levels.

Another sometimes underappreciated aspect of the evaluation is the benefit of a retest. Scores are perhaps most informative about functioning when they change over time. A single evaluation can provide estimates on what might have changed but without a second evaluation, it is impossible to firmly establish what actually has changed. Retesting, particularly after some kind of intervention, can provide valuable insights on how your child has progressed and which areas still need to be addressed. Chapter 3 describes how neuropsychologists interpret test results within the report.

As might be expected, neuropsychologists write neuropsychological reports. However, sometimes parents will read reports that are "psychodiagnostic," or "educational," or even "psychoeducational." What exactly differentiates these reports? The truth is, there is no easy answer as there are not any strict regulations on what psychologists must call their reports. However, some general guidelines can be offered.

***Neuropsychological Evaluation:*** These evaluations assess IQ, achievement, and several cognitive domains such as memory, attention, and executive functioning (see Chapter 5 for details on these terms). Academic achievement is also addressed. Most neuropsychologists also assess for emotional functioning. This report tends to be the most comprehensive, and is the most likely to address more difficult referral questions including ones in which a medical illness is involved. If your child has significant learning issues, notable neurological or medical history, multiple disorders, or there is a need to rule out one or more multiple diagnosis, then this evaluation would best suit your needs.

***Psychoeducational/Educational Evaluation:*** These evaluations, which can be conducted by any qualified psychologist, usually just include IQ and achievement testing, with less emphasis on other cognitive domains and emotional functioning. The reports are often sufficient in addressing questions of learning disabilities and ADHD and suffice for requests for accommodations. Sometimes, psychoeducational reports are more comprehensive and resemble neuropsychological evaluations.

***Psychodiagnostic Evaluation:*** This is the classical term used for assessments and does not require any cognitive testing. Psychodiagnostic evaluations are primarily concerned with personality and emotional functioning and will typically look for depression, anxiety, and other underlying psychological conditions. Sometimes, cognitive testing is included in this evaluation although usually it is minimal in nature. Therefore, this type of evaluation is most suitable when achievement and cognition are not a concern while emotional functioning is the question at hand. Please be aware that some clinicians will interchangeably use the terms “psychodiagnostic” and “psychoeducational” when referring to the same report.

***Intellectual Assessment:*** Some programs and schools only admit children who surpass a cutoff score on an IQ test. IQ tests usually take 1.5–2.5 hours depending on the child’s performance. If the sole purpose of an evaluation is to obtain this score for admittance to such a program, then any qualified psychologist is eligible to conduct this assessment. Due to the straightforward nature of the questions, the cost of such a service should be considerably lower than a full evaluation. However, IQ tests alone will tell you little about your child (other than whether he or she can enter a program). See Chapter 4 for more discussion on intelligence tests.

Ask your practitioner which type of evaluation is most suitable for your needs. Some professionals conduct all of these services (even at



varying costs) while others might refer to a colleague who would be a better match for your child.

### **The Where**

At first, the setting for an assessment might seem less important than other factors, but it merits some consideration. Assessments can be conducted at hospitals and mental health clinics. Such settings have highly trained individuals, many who conduct research and teach, and are more likely to take insurance. On the other hand, there is often less access to practitioners and wait times for some centers can be lengthy. Hospitals might also be intimidating for children and are not always necessary, particularly when a school-related evaluation is requested.

Most private practitioners will have an office that is designed for assessments. Look for rooms that are soundproof and welcoming. Chairs and other furniture should be child-sized and child-friendly. Toys, books, and a friendly office staff will also ensure that your child is comfortable and will perform to his or her best during the examination.

Some parents raise the question of in-home assessments. There are different perspectives on this – on the positive side, such assessments usually guarantee that the child will be very comfortable. Comfort allows for a stronger measure of test results and a more successful evaluation. However, there are more random factors that can interfere with the evaluation. Pets, phone calls, and other family members might distract the child (see footnote 3). Houses are not always easily set up for testing. If you would like an in-home assessment, speak with your practitioner and see if it is an option. If it is, try to find a quiet room where your child won't be overly distracted. There should be comfortable chairs and a low, wide table where the tests can be easily administered.

Assessments at school have the convenience of minimizing time away from school. If the child likes his or her school, it sometimes

can also be relaxing due to its familiarity. At the same time, one must be mindful that other children are around and some may notice your child engaging in a different activity. Children who are self-conscious might be reluctant to undergo testing where their friends might notice them. If the neuropsychologist has a good relationship with the school and you trust that this relationship will help your child, then it may be an option but speak with everyone involved (including your child) to ascertain whether this is a good option.

### **The When**

There are two 'whens' to consider; when during the day, and when during your child's life. With regard to the day, keep in mind that each session usually runs between 2-8 hours. Clarify with the neuropsychologist the number of days and estimated length of each session. A full eight-hour session is generally not recommended unless your child is an older adolescent or adult with few attentional issues. When splitting up the evaluation, it's best to do the evaluation early in day so the child is as fresh as possible to focus on the tests. Sometimes, testing has to be done after school and/or in the evening. If so, a competent neuropsychologist would make note of this, along with any other external factors that might impact performance.

The age at which you bring your child for an assessment often depends on the referral question. Many of the tests are unreliable in very young children. For example, standard IQ and achievement tests are less likely to produce stable scores in children who are under six. Therefore, formal assessments of academic delays and learning disabilities might be a bit premature until a child has completed kindergarten, or even the first grade. Children who are between 2-4 years of age are often referred due to behavioral and communication concerns. Issues relating to social behavior, impulsivity, and hyperactivity might be raised. Trained practitioners can detect signs of an autistic spectrum disorder around this age with accuracy. Therefore,

the question of an autistic spectrum disorder is an appropriate one to answer when evaluating a child of this age.

Other conditions, such as ADHD, developmental coordination disorders, and communication disorders, might be investigated, but at such a young age any diagnoses should generally be provisional in nature. There are a number of reasons that children might act out at this age and many factors must be considered before coming to one of these diagnoses. In addition, some children develop a bit slower than others and so may initially exhibit problematic behaviors in preschool that resolve as the child matures.

Elementary school is a time when learning issues often emerge. If a child does have an attentional issue, it will emerge more prominently the older the child becomes. Elementary schools typically start assigning more responsibilities, such as homework, around the second or third grade and this is when ADHD may particularly impact school achievement. A second “risk” period in elementary school occurs towards its end, as the child begins the transition towards middle school. Homework assignments often become more conceptual and self-initiated, and social pressures may further impact schoolwork as the child begins to navigate the challenges of adolescence.

Adolescence, of course, comes with its pressures and responsibilities. Children with milder attentional or learning issues might struggle more as midterms, final exams, and take-home projects become more frequent. Many of these undiagnosed youths with high intelligence and motivation can often navigate through elementary school on their own, but begin to buckle under the pressures of middle and high school. Adolescents have more responsibility structuring their time around a busy schedule of school, friendships, sports, and other extracurricular activities. This is a challenge for virtually all teenagers and may particularly impact those who have undiagnosed conditions. Even if a cognitive or learning diagnosis is not involved, adolescents still have to navigate the complex social and academic demands placed on them, and a comprehensive evaluation

can provide insights on how a teenager best learns and what can be implemented to help him or her thrive.

Many parents (and their children) express interest in an evaluation for the college years. Such evaluations, whether they are conducted right before college or by the end of freshman year, can be instrumental in providing academic accommodations that will help address any learning issues. Finally, even the post-college young adult might benefit from an evaluation to provide a path towards occupational success, as well as identify underlying emotional or personality factors that might be contributing to current problems.

An evaluation can be informative at virtually any stage of a child's development. In my opinion, there are particularly crucial transitional years when issues might emerge. These include preschool, second/third grade, sixth grade, and tenth/eleventh grade. Generally speaking, these years usually coincide with major academic shifts at school, as well as developmental changes in children themselves. Such transitions are always a risk factor for new problems to emerge and for a previously undiagnosed issue to become more prominent.

Finally, parents sometimes wonder when in the school year an evaluation is most appropriate. It is sometimes premature to evaluate a child who just started a new grade (see "The Why" section below) as children often struggle initially and then settle into a routine. A good time to begin the process of an evaluation would be about 6–8 weeks into the school year if the problem still persists, at which point it is still early enough in the year to implement accommodations in the fall. If the evaluation is not conducted by then, it should be done at least prior to the next quarter/semester so that accommodations can be implemented by then. Late spring and summer are often good times as well, both in terms of your schedule and the school's schedule, so that preparations can be made for the following year. Please note that if you are seeking testing accommodations for your child, it's best to have a copy of the report in your hands a full quarter (i.e. three months) prior to the next exam. This provides all parties ample

time to prepare and process paperwork, as well as make petitions should any complications arise.

### **The Why (Nots)**

“The Why” is quite broad and much of this book addresses why you might have your child assessed. Therefore, it might be useful to discuss some of the “Why Nots,” or circumstances when a neuropsychological evaluation is *not* necessarily the best route to take.

***During transitional periods:*** Children typically prefer routine, and disruptions in routine can be frightening and upsetting. It is perfectly normal to see a change in your child during major transitions, such as a new school, a new home, or a new addition to the family. At the start of the semester, new teachers and new expectations might be an initial struggle for children. Most children will adapt within a month or so and it might be premature to seek an assessment prior to this month passing.

***Reevaluating a child for accommodations when there is little change:*** This is a bit trickier, because neuropsychologists are certainly an appropriate referral to assess your child when you are seeking additional accommodations. I believe the key word here is “reevaluate,” such that a learning disability or another diagnosis has already been established, and you already have a report in your hand. If your child is progressing reasonably well in school, and you simply wish to undergo a revaluation so that he or she may be eligible for accommodations at a new high school or college, then a psychoeducational report (e.g. just IQ and achievement testing) would likely suffice. However, if additional complications that emerge, from either a learning, cognitive, or emotional level, then a full neuropsychological evaluation would be more appropriate.

***There is minimal cognitive concern:*** Sometimes, the issue at hand is clearly emotional, with little concern for a cognitive change. For

example, a middle schooler who is experiencing depression and some substance use might be academically underperforming, but if he did very well up until these recent events, then a full neurocognitive battery may not be warranted. This child certainly should see a mental health professional to help overcome obstacles, but unless there is a suspected cognitive issue contributing to the problem (which there very well might be in some circumstances), then it is uncertain what a neuropsychological evaluation would contribute above and beyond a standard intake during therapy. Do note that in younger children, cognitive disturbances are more difficult to outright observe as they sometimes manifest as behavioral problems, and so an evaluation may be more appropriate to rule out a diagnoses.

***Within a year after an evaluation:*** Unless you are seeking a second opinion, reevaluations should be spaced apart. The exact timing for this varies depending on the nature of the issue, but in general you want to let at least a year pass to allow your child to further develop and benefit from tutoring. There are some exceptions, such as when a child is in a crisis mode or has suffered a severe neurological injury (see footnote 4), although usually shorter batteries that primarily focus on acute disturbances are then appropriate.

#### FOOTNOTE 1

The Houston Guidelines (discussed in the appendix) mandate the following requirements for a neuropsychologist to be board eligible. First, they must have a doctoral degree in psychology and have a license to practice as a psychologist. They then have to engage in a two-year postdoctoral program (or its equivalent over a longer period of time). Such programs can be at a formal training institute or a private practice. Fellows must demonstrate competency across eight knowledge areas that include aspects of neuroscience, psychology, and neurology. During

their postdoctoral studies, at least 50% of their time must involve neuropsychological evaluation under the supervision of another neuropsychologist. All applicants must submit their credentials to the American Board of Clinical Neuropsychology (ABCN) who review it. Eligible applicants are invited to formally apply, which involves passing a written and oral examine and submitting de-identified reports for panel review.

## FOOTNOTE 2

Parents might notice that relatively few private child neuropsychologists take insurance, in part because it can be difficult to obtain reimbursement. Insurance often pays only a small portion of what a neuropsychologist typically charges, and some companies will deny services that are not deemed to be medically necessary (as school-related evaluations can be perceived). At the same time, neuropsychologists who do take insurance often find the experience rewarding as they can serve additional families and the community, and often the reimbursement is enough to make a reasonable living. If a neuropsychologist does not take insurance, see if they are willing to provide you with a "superbill," which can be submitted to your insurance company as the services of an out-of-network provider. Depending on your policy, you may be reimbursed a portion of your cost, although this is not a guarantee. If you are trying to save money, speak to both your insurance company about out-of-network reimbursement, and to your neuropsychologist to see if you can find a situation that is satisfactory for all parties.

**FOOTNOTE 3**

I sometimes engage in in-home assessments, particularly when there might be a clinically indicated reason. One way to handle these situations is to take everything that happens during the assessment as a possible indicator of something (e.g. everything is "grist for the mill," so to speak). I remember evaluating one young boy in his parents' kitchen. Unfortunately, during a timed test of sustained attention and concentration, the family dog broke in and started barking at something outside. To my surprise, my patient was able to maintain his focus on this test and performed well above the average range - certainly a pertinent observation if there ever was one!

**FOOTNOTE 4**

Traumatic brain injury is a very frightening prospect for parents. Fortunately, most injuries are mild in nature and have few if any longstanding problems (see Chapter 13 for more detail). Sometimes, however, the injury is severe enough that there is a real possibility of permanent damage. Most children will make their most profound gains in the first few months, with progress slowing by the end of the first year after injury. Studies have shown that there is minimal recovery of lost functions by the end of the first year. Therefore, frequent and brief assessments between the first few weeks after injury up to the first year can objectively measure recovery patterns. Note that such assessments will almost always be done in a medical setting, with little need to include an outside private practitioner (unless you are seeking an evaluation well after recovery is completed).



## CHAPTER 2

# Myths, Facts, and Questions to Ask

*There are a number of myths about the negative effects of an evaluation. This chapter will dispel some of the more common ones.*

### **Myth 1: “This evaluation will put a label on my child.”**

Parents may fear that testing will show that their child is slow, or behind, or a “problem student” and that such results will have long lasting negative consequences. For example, such children might be denied admittance to school or college or be placed in the “bad group” at school. While understandable, such fears are usually unfounded. First of all, parents own the rights to their child’s evaluation and therefore have control over who can read it. This should assuage any concerns that findings or possible diagnoses will be made public; if you don’t want anyone else to know the results then that is your right as the legal guardian.

Furthermore, a child who has a real learning or cognitive issue will struggle if this issue is not identified – at best, they might just

consistently be behind in school while at worst, they might be accused of being lazy or unmotivated, be ostracized by teachers and peers, and may lose self-esteem. These are the real negative consequences that all too often occur when the real problem is not identified. Finally, testing doesn't just reveal weaknesses – a child's personal strengths also shine through in the evaluation. By identifying these strengths, they can be celebrated with the child and used to help compensate for any actual weaknesses that may exist.

**Myth 2: "The school wants an evaluation to find a reason to tell us that our child isn't a fit for them."**

It is unlikely for an evaluation to be a determinant in making such a difficult decision, because evaluations are generally recommended when teachers have identified an issue with your child and want more information on how to best help him or her thrive in class. As such, evaluations are preventative— by learning your child's strengths and weaknesses, this helps teachers, parents, and ultimately the child him/herself work better at the school.

**Myth 3: "My child's self-esteem will be hurt by the evaluation."**

As mentioned, a child's strengths as well as personal weaknesses are identified. Many neuropsychologists are willing to provide age-appropriate feedback directly to your child and highlight findings. Speaking personally, my most profound feedbacks were directly to the child, who learned a few new things about him or herself and took the positive news to heart with longstanding improvements.

**Myth 4: "My child will inevitably be diagnosed with ADHD if s/he undergoes an evaluation."**

It is true that ADHD can be overdiagnosed. However, just because there may be an overabundance of diagnoses does not invalidate the

condition itself. Suspicion of ADHD is certainly a common reason why children are referred for an evaluation, but for most psychologists it is but one of several possible explanations. Adjusting to life changes, mood and emotional factors, and learning disorders are other frequent explanations for what may initially seem like an attentional diagnosis. Even if ADHD is the ultimate explanation for what is going on, it is much better to have the right answer rather than hope that it is simply a phase that will eventually go away on its own.

**Myth 5: “The evaluation might diagnose my child but what’s the point? A diagnosis won’t do anything for my child.”**

A diagnosis is only the first step towards building an intervention plan, but it is an important one. It is true that a diagnosis by itself without further action will do little good. On the flip side, a diagnosis alone is not a ‘magic bullet’. It is a conduit towards having a conversation with the parents, teachers, learning specialists and the child themselves.

### **Questions to Ask**

Here are some sample questions you may want to ask your neuropsychologist. This is not exhaustive and not all questions will pertain to your situation, but these can serve as a starting point.

- 1 Did you complete a neuropsychology fellowship?
- 2 Are you board certified in neuropsychology? If not, are you board eligible?
- 3 How many years have you been in practice?
- 4 What kind of populations do you work with?
- 5 What settings have you worked at? Hospitals? Private practices? Schools?

- 6 Tell me a bit about your assessment process:
  - a How long do your assessments take?
  - b How many visits can we anticipate, and how long should each visit be?
  - c Do you conduct school observations?
  - d What is your turnaround time for reports?
  - e Will you be willing to speak to my child's teachers, pediatricians, etc?
  - f Who is involved during the feedback session?
  - g Are you available for follow-up after the assessment is completed?
- 7 How much do you charge for your services?
  - a Do you take insurance?
  - b Do you offer a different rate for different services (e.g. a shorter battery for a reevaluation or an IQ test)?
  - c Do you charge a flat rate for all services?
- 8 Do you ever do in-home assessments? Would you do an assessment at my child's school?
- 9 Is this a good time for my child's assessment? Should we wait or should we schedule something as soon as possible?
- 10 Do you think that a full neuropsychological evaluation will help figure out what is going on?