THE CENTER for Psychological Services

TESTING INTAKE PACKET

Dear Client:

Welcome to The Center For Psychological Services Ltd. Attached you will find our registration packet which includes the following forms:

I. BIOGRAPHICAL INFORMATION

II. TESTING POLICY & AGREEMENT FOR SERVICES

III. LIMITS OF CONFIDENTIALITY

IV. HIPAA: NOTICE OF PRIVACY PRACTICES (*signature page)*

V. ELECTRONIC COMMUNICATIONS STATEMENT

Please take time to read over the information and sign where necessary. *Be sure to ask your doctor or therapist any questions you may have.*

We look forward to working closely with you on making changes that you and/or your family members hope to make as a result of the testing process. We have found that those who experience the most successful outcomes here have:

1. **Clearly defined testing goals**
2. **Formed an effective working relationship** with their evaluator. Be sure to talk over any concerns or questions you have about the testing process.
3. **Kept appointments as scheduled**; each visit builds on the ones before.
4. **Done any recommended "homework"** between appointments. Completing any documentation prior to testing appointment.

The Center is deeply committed to providing you with the highest quality comprehensive state-of-the-art behavioral health services for children, adolescents, adults, couples, and families. We utilize a variety of therapeutic approaches and services to help you successfully adapt and balance life's stressors and challenges as you move toward a fuller, richer life. We thank you for placing your confidence in us and look forward to meeting with you.

Sincerely,
Victoria L. Williams, MSN, Psy.D., LCP
Licensed Clinical Psychologist
Director, The Center for Psychological Services, Ltd.

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SECTION I: BIOGRAPHICAL INFORMATION

Date: _____ Therapist here to see: _____

CLIENT NAME: _____ DOB: _____ AGE: _____

SEX: __M __ F__ MARITAL STATUS: __ single __ married __ divorced __
Preferred Pronoun: _____ __ separated __ widow __ minor

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

Home #: (___) ___ - _____ List Family Members / Ages: _____
Cell #: (___) ___ - _____ _____
Work #: (___) ___ - _____. _____

Please indicate preferred contact # _____ May we leave a message: ___ yes ___ no

Our system generates automatic reminder calls or texts to your preferred #.
Please check to choose format: **Call** - _____ **Text-** _____ **No Reminder-**_____

If you have any special direction concerning mail delivery to your stated address please note here:
_____

EMPLOYER: _____ OCCUPATION/POSITION:_____

EMERGENCY CONTACT: _____ RELATIONSHIP TO CLIENT: _____
EMERGENCY CONTACT PHONE #:(___) ___ - _____.

If there should be a need for us to contact your emergency contact person, we will only disclose any information that is related to the emergency situation. Please initial here that you understand this.

I understand that in an emergency situation, relevant information will be disclosed. _____
initial

If client is a minor, please complete the following:

WHO DOES MINOR RESIDE WITH: _____RELATIONSHIP TO CLIENT:_____
NAME OF RESPONSIBLE PARTY: _____ SCHOOL/GRADE:_____

How did you hear about us?

___ website: ___ friend: ___ relative: ___ school: ___ physician: ___ other: _____

FOR OFFICE USE:
DX: _____ Session fee: _____ Agreement for Services form read & signed __ Yes __ No
copy of insurance card ___ Driver's license ____ Credit card on file ____

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SYMPTOMS

Check the box beside each concern experienced recently

☐ Anxiety	☐ Depression	☐ Sleeping Problems	☐ Thoughts of Suicide
☐ Panic	☐ Unusual thoughts	☐ Anger Outbursts	☐ Weight Change
☐ Crying Spells	☐ Memory Problems	☐ Sexual Problems	☐ Relationship Issues
☐ Treated Unfairly	☐ Frequent Pain	☐ Low Energy/Lethargic	☐ Concentration problems
☐ Restlessness	☐ Nausea	☐ Eating Disorder	☐ Legal Difficulties
☐ Drug Use	☐ Alcohol Abuse/Heavy	☐ Boredom	☐ Hopelessness
☐ Stress	☐ Shyness	☐ Work Problems	☐ Confusion
☐ Feelings of Guilt	☐ Suspicion	☐ Loneliness	☐ Violent Thoughts
☐ Compulsions	☐ Worry	☐ Financial Problems	☐ Difficulty with decisions
☐ Specific Fears	☐ Mourning	☐ Physical Illness	☐ Lack of Motivation
☐ Feeling Abandoned	☐ Meaninglessness	☐ Perfectionism	☐ Unusually Sensitive
☐ Irritability	☐ Social Withdrawal	☐ Feeling Misunderstood	☐ Troublesome Thoughts
☐ Religious Concerns	☐ Disappointment	☐ Impulsive Behavior	☐ Hearing strange voices
☐ Feelings of Inferiority	☐ Irrational Thoughts	☐ Mood Swings	☐ No Present Concerns

Enter any additional concerns or symptoms in the blank space below:

_____

_____

_____

What stresses or life changes have you experienced recently?

_____

_____

_____

Have you seen a therapist in the past?

Year	Problem	Therapist or Clinic	Treatment Duration

Your family growing up:

Relationship	First Name	Personality / Mental health issues
Mother		
Father		

If you need more space for additional family members please continue below:

_____

_____

_____

Where are you currently living?

- ☐ Dorm/Campus Apartment
- ☐ Apartment
- ☐ House
- ☐ Other
- ☐ Health Care Facility
- ☐ Retirement Community
- ☐ With Relatives

Who lives with you now?

_____

Childhood

Check the box beside issues experienced in childhood:

☐ Happy Childhood	☐ Neglected	☐ Moved Frequently
☐ Physically Abused	☐ Few Friends	☐ Sexually Abused
☐ Weight Problems	☐ Popular	☐ Parents Divorced
☐ Family Fights	☐ Poor Grades	☐ Conflict with Teachers
☐ Drug/Alcohol Use	☐ Good Grades	☐ Sexual Problems
☐ Depressed	☐ "Spoiled"	☐ Anxious
☐ Not Allowed to Grow-Up	☐ Attention Problems	☐ Anger Problems

Enter any additional childhood experiences or symptoms in the space below:

_____

_____

_____

Relationship History

How many times have you been married? _____

How old were you at the time of your marriage(s)? _____

Briefly describe any problems in your current or past marriages or cohabitation relationships:

_____

_____

_____

Education and Occupation

Are you currently - (circle one) Working Unemployed in school

Highest level of education completed?

_____

What is (or was) your major or favorite subject? _____

How many hours per week are you working? _____

In what field do you usually work? _____

Briefly describe what you like and dislike about your employment or school:

_____

_____

Home Life

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic relationships and friendships:

_____

_____

_____

Health

Check each accident or illness you have experienced:

- ☐ Recent surgery
- ☐ Seizures
- ☐ Drug/alcohol abuse treatment
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Infertility
- ☐ Head injury
- ☐ Thyroid problems
- ☐ Neurological disorder
- ☐ Headaches
- ☐ Hormone problems
- ☐ Miscarriages

List any other chronic health problems you may have:

_____
_____
_____

How many hours do you sleep in an average night? _____

How many drinks (containing alcohol) do you consume in an average week? _____

Which recreational drugs have you used in the last year? _____

List any prescription or over-the-counter medications you may take, along with the purpose of medicine?

_____
_____
_____

Do you exercise? How? How often?

_____

Do you use tobacco? How much?

_____

Who is your primary physician? (Include phone number if known.)

_____
_____
_____

When was your last physical? _____

Are you concerned about your physical health?

_____

Accomplishments & Additional Information

List your personal strengths and important accomplishments:

_____
_____
_____

THE CENTER for Psychological Services

SECTION II - TESTING POLICY & AGREEMENT FOR SERVICES

Our team of clinical psychologists and supervised psychometricians provide psychological, neuropsychological and psycho-educational testing for a variety of purposes. We encourage you to read the following details in an effort to make an informed decision about our testing process.

Psychological testing and evaluation can have benefits and risks. These services often lead to better relationships, significant reductions in feelings of distress, and better performance in school or work. On the other hand, since these services often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings (e.g., sadness, shame, guilt, anger). You may even feel worse for a period of time.

A. HOW IS TESTING USEFUL?

Testing is useful in identifying strengths and weaknesses in the areas of intelligence, academics, social skills, personality, executive functioning and behavior. This can be used for the purposes of diagnosis and treatment planning to improve functioning at home and work. A client can be self-referred, or referred by their physician, their therapist, or specialist, or school, when there are questions that cannot be answered by a clinical interview alone.

B. WHAT IS INVOLVED IN TESTING?

Testing is a process. Testing involves not only the administration of tests, but the scoring and interpretation of them, as well as writing a report that explains the results and provides recommendations for appropriate treatment or intervention.

1. On your first consultation, we will conduct an initial interview to gather thorough background information and discuss current problems or symptoms and goals of testing. During this visit, you will also complete registration information, and discuss the number of tests to be administered, and the amount of time needed for testing (depending on the referral questions).

2. Depending on the purpose of testing, test administration may be completed in one or more sessions.

3. Following test administration, the clinician will need time for scoring, interpretation of the test data, and completion of a thorough report. The clinician will discuss with you the projected length of time for completion. Although this step of the process is time intensive, we strive to complete it in a timely manner. Though the client is not present for this step, there is an hourly charge submitted to the insurance for the time needed to complete the test scoring and report writing.

4. Finally, a follow-up session will be scheduled to review the results and discuss recommendations for appropriate treatment or intervention. This is also billed on an hourly basis.

Generally, the intake, face-to-face testing, scoring, report preparation and writing, plus the feedback session can total approximately 12 or more billable hours.

C. WHO HAS ACCESS TO THE TEST RESULTS?

Your test results are treated with the strictest confidence according to HIPAA laws.

Test results are usually only released to the client (or in the case of minors, to the parents). However, if you need us to send copies of the report to the referring professional (psychologist, neuropsychologist, psychiatrist, primary care physician, therapist, school professional), you must give us written permission by signing a formal release of information.

D. IF YOU HAVE A CHILD TESTED, CAN THEY RECEIVE SPECIAL SERVICES AT SCHOOL?

Very often, psychological, neuropsychological and psycho-educational testing is conducted to identify problems that interfere with a child's learning. Test results may help with school planning. We make every effort to work with the school to explain the testing results and recommendations.

The psychologist can be available to attend meetings at the school and to consult with the school as needed. The charges for these extra services are not covered by insurance and will be charged at our hourly rate.

E. HOW MUCH DOES TESTING COST?

Each client presents unique needs. Therefore, cost varies depending on the test battery needed to complete a thorough assessment. The cost also varies depending on your insurance coverage. This will discussed with you prior to, or during the initial interview session.

The supervising psychologist and/or psychometric staff has set aside hours with the expectation that you will attend the appointment. If you need to cancel an appointment for testing, a minimum of 24 hours advance notice must be given. If a client fails to provide adequate notice, they will be charged $150 for the time that has been set aside.

Cancellations or missed appointment fees are not covered by insurance. The missed appointment fee of $150 must be paid before rescheduling the testing session.

PAYMENT TERMS AND INSURANCE

When you initiate services, our Billing Office will obtain a **quote of benefits from your insurance company** and will share that information with you. ***(as a reminder, this is a quote of benefits, not a guarantee of payment)***

If our Center is not a participating provider for services in your insurance plan, we will supply you with the invoice necessary to submit to your insurance company. We also offer a "fee for service" option.

Your portion of the session fee is due at the point of service. Please check in with our Front Desk to pay fees before your session; should our Front Desk not be available, kindly pay your tester by the end of your session. If someone from your family is receiving services and not responsible for payment, please be sure payment arrangements are made before the session. We welcome credit cards, cash or check; there is a $30 charge for returned checks.

CONTACTING YOUR PSYCHOLOGIST/PSYCHOMETRICIAN

We check our voicemails throughout the business day at the Center and return calls typically within 24 hours except weekends and holidays. When leaving a voicemail or electronic communication, please be specific and brief.

If for unseen reasons, you do not hear from us or there is difficulty in reaching you, and safety is a concern for you or your child, please go to your nearest Emergency Room or call 911 and ask to speak to the mental health worker on call.

SECTION III - LIMITS OF CONFIDENTIALITY

In general, the privacy of all communications between client and therapist or psychologist is protected by law, and we can only release information about our work to others with your written permission. **But, there are a few exceptions**:

- In most legal proceedings, you have the right to prevent us from providing any information about your treatment. *In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony.* However, such an order is unlikely. We would advise you never to agree to any release of information without first discussing it with us.

- There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, *if we believe that a child, elderly person or disabled person is being abused, we must file a report with the appropriate state agency.*

- *If we believe that a client is threatening bodily harm to another, we may be required to take protective actions.* These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for our clients.

- *If a client threatens harm to herself/himself, we may be obligated to seek a higher level of care including hospitalization, and/or to contact family members who may help provide protection.* If a similar situation occurs in the course of our work together, we will attempt to fully discuss it with you before taking any action.

The prior situations have rarely occurred in our practice. ***If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.***

We may occasionally find it helpful to consult with other professionals about a client in order to provide best care. During a consultation, we make every effort to completely disguise the identity of each client. Consultants are also legally bound to keep information confidential. If you don't object, we typically will not tell you about these consultations unless we believe it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful about potential exceptions to confidentiality, *it is important to discuss any questions or concerns that you may have as we go along*. We will be more than happy to discuss these issues with you. Please note, however, that we are not an attorneys, and formal legal advice is sometimes warranted because the laws governing confidentiality are quite complex.

_____

Signature of parent/guardian (responsible party) Date **Printed name** of parent/guardian

_____

Signature of client to be tested Date **Printed name** of client to be tested

_____

Signature of psychologist/psychometrician Date **Printed name** of psychologist/psychometrician

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SECTION IV - HIPAA- NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) - *notice of policy and practices to protect the privacy of your health information.*

Please review the HIPAA policy document and sign & date below that you have read it:

I, _____ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax:

I fully understand and accept the terms of this consent.

_____

Signature of client to be tested Date **Printed name** of client to be tested

*** Parent/guardian of child (12 yrs and younger) must sign HIPAA statement*

SECTION V: ELECTRONIC COMMUNICATIONS STATEMENT

Electronic Medical Records/Communication:
At The Center for Psychological Services, we use an electronic medical records system and patient portal messaging system that is HIPAA compliant.

Email Communication:
This form of communication is not advised. Please use the "message" feature via your Patient Portal.

Text Communication:
Should you have an agreement with your therapist to utilize texting as means to communicate, Please be advised that due to the nature of variable security measures and phone service providers, we do not encourage or promote a text exchange that goes beyond non-personal dialogue, i.e. rescheduling/confirming an appointment.

Social Media:
Our center policy is to not communicate with clients through social media platforms like Twitter, or Facebook. In addition, if your therapist discovers that he/she has accidentally established an online relationship with you, they will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Website:

We have a website which we use for professional reasons to provide information to others about our practice. You are welcome to access and review the information that is on the website, and if you have any questions about it, we should discuss this during your therapy sessions.

_____

Signature of client (at least 12 yrs of age) Date **Printed name** of client