**Tompkins & Associates**

Licensed Clinical Psychologists

# Specializing in the Treatment of Children and Their Families

**Informed Consent for Psychological Assessment**

**Minor**

Welcome to Tompkins and Associates. This document contains important information about professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between Tompkins and Associates and you.

**Psychological Evaluation Services**

Purpose of Assessment:

The primary purpose of the psychological assessment is to evaluate various aspects of your child’s psychological functioning, including but not limited to intelligence, academic skills, emotional well-being, social skills, and behavior. The assessment will help us understand your child’s unique strengths and areas of difficulty, and will guide recommendations for interventions and support.

Nature of Assessment:

The assessment process typically involves a variety of tools and techniques, including standardized tests, interviews, observations, and questionnaires. These methods may vary depending on the specific concerns and goals of the assessment. The assessment will be conducted by qualified professionals who have expertise in child and adolescent psychology.

Confidentiality:

Confidentiality is of utmost importance throughout the assessment process. Information gathered during the assessment will be kept confidential and will only be shared with individuals directly involved in your child’s care, unless otherwise required by law. We will discuss the limits of confidentiality with you before beginning the assessment.

Voluntary Participation:

Participation in the assessment process is entirely voluntary. You have the right to refuse or withdraw your consent at any time without any negative consequences for you or your child. Your decision regarding participation will not affect the services provided to you or your child in any way.

Benefits and Risks:

Participating in the assessment can provide valuable information that may lead to a better understanding of your child’s needs and inform recommendations for interventions and support. However, it is important to acknowledge that assessment results may not always provide clear-cut answers and may not fully capture your child’s strengths and challenges. There may also be a temporary increase in stress or discomfort for your child during certain aspects of the assessment process.

Feedback and Recommendations:

Following the assessment, you will be provided with feedback on the results, including a comprehensive report outlining the findings and recommendations. This feedback session will provide an opportunity for you to ask questions and discuss any concerns you may have.

# **INSURANCE REIMBURSEMENT**

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Tompkins and Associates will electronically file claims for those insurance plans that we are able to bill. We will provide you with documentation to you for any out on network insurance claims and you are responsible for full payment of fees.

You should also be aware that most insurance companies require that we provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records submitted, if requested. ***You*** ***understand that, by using your insurance, you authorize us to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will share your coverage and any out of pocket costs that you may accrue.

 It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by the insurance contract.

# **PROFESSIONAL FEES**

Out of pocket rates, prior to adjustments made based on your insurance coverage are:

The hourly fee for Intake Appointments is $250.

The hourly fee for psychological assessment is $160 for each hour of testing, scoring/interpretation, and report writing completed.

The hourly fee for additional professional services is $160. This fee is prorated as appropriate, based on the service provided. Other professional services include letter writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time spent on your legal matter, even if the request comes from another party.

# **BILLING AND PAYMENTS**

You will be expected to pay for the assessment at the time of service, unless we agree otherwise or unless you have insurance coverage that requires another arrangement.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve billing the balance due to the credit card on file or hiring a collection agency. In most collection situations, the only information we will release regarding a patient’s treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

# **CONTACTING YOUR PROVIDER**

Psychologists and therapists are often not immediately available by telephone. Our phone is answered by our intake coordinator who can get a message to us quickly. You are welcome to leave a message for us at the office’s confidential line (630-717-5911) or you can contact via email. We will make every effort to return your call and emails within 2 business days. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you cannot wait for a returned call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

## **CONFIDENTIALITY**

Parent Authorization for Minor’s Mental Health Treatment

In order to authorize a psychological evaluation for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify us immediately. We will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child’s other parent, please be aware that it is our policy to notify the other parent that we am evaluating your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation.

Mandatory Disclosures of Treatment Information

In some situations, we are required by law or by the guidelines of my profession to disclose information, whether or not we have your or your child’s permission. Some of these situations are below.

Confidentiality cannot be maintained when:

* Child patients tell us they plan to cause serious harm or death to themselves, and we believe they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent or guardian or others of what the child has told us and how serious we believe this threat to be and to try to prevent the occurrence of such harm.
* Child patients tell us they plan to cause serious harm or death to someone else, and we believe they have the intent and ability to carry out this threat in the very near future. In this situation, we must inform a parent or guardian or others, and we may be required to inform the person who is the target of the threatened harm [and the police].
* Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.
* Child patients tell us, or we otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we may be required by law to report the alleged abuse to the appropriate state child-protective agency.
* We am ordered by a court to disclose information.

Disclosure of Minor’s Treatment Records to Parents

Although the laws of IL may give parents the right to see any written records kept about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with us, and you agree not to request access to your child’s written treatment records, unless there are extenuating circumstances.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require my helping to address conflicts between the child’s parents, our role will be strictly limited to providing an evaluation for your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena records or ask the psychologist to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing opinions about parental fitness or custody/visitation arrangements. Please note that we do not provide forensic evaluation related to child custody and our reports should not be used for this purpose.

Please note that your agreement may not prevent a judge from requiring our testimony, even though we will not do so unless legally compelled. If required to testify, we are ethically bound not to give opinions about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided, but we will not make any recommendation about the final decision(s). Furthermore, if required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for our participation agrees to reimburse us at the rate of $160 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/AdolescentPatient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_