MICHIGAN MENTAL WELLNESS
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# Consent for Comprehensive Psychological Assessment

I request that Michigan Mental Wellness conduct a comprehensive psychological assessment with me and/or my child. Assessments are provided by either, a Temporary Limited Licensed Psychologist or Limited License Psychologist and is supervised by Dr. Gresham and Dr. Riehl, our full-time staff psychiatrists, as well as the TLLP/LLP's clinical supervisor, a fully Licensed Psychologist. **This form is to document my permission and consent, as well as my agreement to the conditions of service outlined in this form.**

The assessment will consist of interviews with the patient, possibly other relevant family members and other collateral contacts plus the administration of a battery of measures. I understand that the practice of psychological assessment is not an exact science and so predictions of its benefits, outcomes or duration are not precise or guaranteed. I also understand that assessment is a relatively benign procedure that is usually easily tolerated, however, I may experience some frustration during the testing, when working on challenging tasks. I am welcome and encouraged to discuss with the clinician any and all questions or concerns that I have concerning testing and assessment.

The general layout of an evaluation is as follows, and subject to change based on information gathered during the initial interview:

**Schedule:**

- Pre-Intake Questions
  - Form must be completed and emailed to mmwassessments@gmail.com before initial interview is scheduled.
- Initial assessment interview
  - Initial interview with patient or caregivers to collect background information and review previous testing reports if applicable.
  - Schedule testing appointments
  - Review payment and billing of psychological testing to insurance companies
- Assessment appointments (potentially multiple appointments)
  - Conduct individualized testing and complete self-report measures
  - Distribute parent, teacher, and/or observer rating measures
  - On-site observation or collaboration with other professionals, if necessary.
- Feedback session (scheduled 3 to 6 weeks from the date of the last assessment appointment)
  - Review testing results, interpretation, and recommendations
  - Complete release of information forms for report distribution, if requested

Areas to be assessed may include intellectual and achievement functioning, attention and concentration, psychological status, and emotional adjustment across settings. The comprehensive evaluation may include IQ measures, achievement measures, personality measures, neuropsychological screeners, computer-based assessments, self-reports, questionnaires, as well as screeners for other functional impairments. If any learning disabilities, developmental disabilities, neuropsychological conditions or mental illnesses are detected, these will be diagnosed. Because testing is such an individualized service, total hours needed depends highly upon the selected measures and the time it takes each individual to complete the tasks. If requested, a written report will be produced that describes the results of the assessment and gives detailed recommendations for services that the patient would benefit from, based on the findings. I understand that results from this assessment, and

the written report, will not be shared with anyone other than myself unless I give written permission for such a release of information.

I agree to cancel or reschedule any scheduled appointments at least ***24 hours in advance***. If an appointment is missed without notice, I understand that we will be charged **$100.00** for a missed/late cancel appointment, in consideration for the time reserved.

I understand that communications with a clinician are confidential. No information will be released without my consent, with the following exceptions. By law, the clinician must report suspected child or elder abuse/neglect to the appropriate authorities. In addition, the therapist has a legal duty to break confidentiality if a patient presents an imminent danger to self or other. In case of emergency, information necessary to provide for the care of the patient may be disclosed. I understand that if this patient has other legal guardians, those other persons may have a legal right to access records regarding assessment and treatment. Also, I am aware that if I become involved in litigation in which my mental health or the welfare of a child is at issue, my treatment records and/or the clinician might be subject to subpoena by other parties to the litigation. Confidentiality is an important cornerstone of psychological services and therefore clinicians will only breach confidentiality when compelled to do so by law or when authorized to do so by my legal representative or me.

By signing below, I indicate that I have read, understood and agreed to the contents of this consent.

_____ _____

Signature (patient or guardian) Date

_____

Printed Name