THE spectrum CENTER LLC.

Testing and Counseling services for the autism, gender, ADHD and learning diversity spectrums

1930 Marlton Pike East, Suite J-49, Cherry Hill, NJ 08003 | 856.313.5619 (ph/txt) • 888.496.4170 (fax) | TKoser@SJSpectrumCenter.com

Welcome to The Spectrum Center. This form will provide information about my services and about your rights and responsibilities as a client. Please be sure to discuss any questions with Dr. Koser. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

Informed Consent for Psychological Evaluation

Through the use of a variety of standard psychological tests, I will attempt to answer the questions that have brought you or your child for this assessment. These questions generally concern autism, learning disabilities, academic functioning, general behavior and emotional presentation, personality functioning, or coping styles. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational interview followed by the administration of one or more educational and/or psychological tests. Sometimes interview questions address very personal experiences it may be upsetting to talk about. Although it is sometimes possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed and a report will be written. You will then have the opportunity to meet with Dr. Koser to discuss the results and receive a copy of the report.

Person being evaluated: _____

Types of Evaluations

□ Psycho-Educational Evaluation. The purpose of this evaluation is to provide an in-depth study of the cognitive processes, academic achievement, and personality functioning of an individual. This evaluation can also be used to diagnose learning, behavioral, and psychiatric disorders.

□ Autism Diagnostic Testing. The purpose of this evaluation it to assess whether the individual has a developmental history and presentation consistent with a diagnosis of Autism Spectrum Disorder or other related developmental disorders.

□ Diagnostic Evaluation. The purpose of this evaluation is to diagnose behavioral or emotional disorders such as ADHD, anxiety or depression, and other mental health conditions.

□ Learning, Attention, or Personality Screening. The purpose of this evaluation is to provide a brief assessment of cognitive, academic, or personality functioning that may be contributing to academic or behavioral problems. The results may indicate whether a more in-depth study is necessary.

□ Gender Confirmation Recommendation / Informed Consent Letter

□ Other_____

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It is important to understand that The Spectrum Center does not perform custody evaluations for children, which is a highly specialized field. In addition, The Spectrum Center does not perform forensic psychological evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation). If you are considering using the results of an evaluation for a custody dispute or for legal purposes, please consult with experts in those areas.

Types of Measures
The type(s) of measures you or your child may receive include:

□ Cognitive Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension, perceptual reasoning, working memory, and processing speed.

□ Memory Testing – to assess overall intellectual ability, as well as strengths and weaknesses in verbal comprehension, perceptual reasoning, working memory, and processing speed.

□ Academic Achievement Testing – may be in the areas of word reading, phonics, reading comprehension, written language, math reasoning and calculations, and academic fluency. Measures of oral language may also be obtained.

□ Attention and Executive Functioning Testing – to assess attentional processes, along with any difficulties pertaining to initiation, sustained effort, emotional modulation, ability to monitor and self-correct, working memory, organization and planning.

□ Diagnostic Interview and Developmental History – to obtain information about the examinee outside of the testing situation, and to obtain a comprehensive history in order to make a more reliable diagnosis.

□ Behavior Rating Scales and/or on-site behavioral observation at school in order to get a sample of behavior that occurs outside the office setting.

□ Social/Emotional Assessment – to obtain information of the individual pertaining to diagnosis, interpersonal relationships, self-concept, etc.

□ Interviews with teachers, other family members, physicians, or other relevant individuals (Note: interviews will only be performed with written consent).

□ Informed Consent interview and gender history

□ Other: _____

_____

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Clinicians/Evaluators
The following clinician(s) are assigned by Dr. Koser and will be managing the case:
□ Dr. Koser, NJ & PA Licensed Psychologist □ Dr. Cote, NJ Licensed Psychologist

□ Dr. Burke, Post-Doctoral Fellow

Feedback
The type(s) of feedback you (and possibly your child) will receive may include:

□ In-person, verbal feedback.

□ A comprehensive written report that provides findings for each measure, an integrative summary, and recommendations for treatment and/or other interventions.

□ A brief, written summary report (approximately one page) that provides an overview of findings and recommendations.

□ Other: _____

Fee and Payment Policy
The fee for an evaluation is based on the number and type of tests included in the assessment battery. The fee may be adjusted at times depending upon the purpose of the evaluation and the tests used. The fee will be noted in the space below. The Spectrum Center does not bill insurance companies. Dr. Koser will provide a receipt for services you can use to submit to your insurance company for out-of-network re-imbursement. Your individual coverage, deductible, and other factors will affect whether you receive any re-imbursement for the services provided. Half of the fee must be paid at the initial appointment, and the remaining half is due at the feedback session. The Spectrum Center accepts cash, checks, or the following credit cards: Visa, MasterCard, American Express, and Discover.

Questions concerning the fee or payment policies should be discussed with Dr. Koser before the assessment process begins. An additional fee of $120 per hour may be charged for arriving late or missed appointments without 2 business days notice (feedback sessions = 2 hours).

In the event of an insufficient funds (bounced) check, you are responsible for the check amount plus any bank charges incurred by The Spectrum Center. Outstanding balances due for over 60 days may be reported to a collections agency along with some of your information related to recovery of the outstanding balance.

____ [initials] You are aware that full payment for the assessment must be paid in full no later than the start of the feedback session.

____ [initials] Total Fee for Testing: $_____

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Request for Accommodations
For clients requesting accommodations for Learning Disability or Attention-Deficit/Hyperactivity Disorder (ADHD), a psychological test report will be provided to the appropriate agency. We will only release these records after you have signed a consent form. Should the agency request specific information (such as a particular report format or an additional form), this will be provided at an additional cost if requiring more than 2 hours of additional time. At least two weeks notice is required to complete any additional forms.

Direct transmission of Records
Some evaluations and mental health exams are for purposes that require results be transmitted directly to a third party (adoption agency, employer, etc.) If these circumstances apply, release and transmission information is included below.

____ [initials] You are requesting the results of this evaluation be transmitted directly to the third party named below.

Name: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Country: _____

Phone: _____ Fax: _____

Release of Records
Written records are released only after an authorization form is signed by me, or for my child as their Parent/Legal Guardian.

Receipt of Policy Documents
The HIPAA privacy notice and information for The Spectrum Center is available for review. A copy of the privacy policies will be offered to you to have and retain for your records.

Electronic Communications
For ease of communication, you can contact Dr. Koser by phone, text, email, and through inquiries sent via his secure patient portal. It is important for you to know that email is essentially a public communication method, somewhat like an electronic post-card. Any information you send to Dr. Koser by email may be able to be viewed by others. Critical information and emergencies should only be communicated through in-person contact face-to-face or by telephone to ensure the intended person receives it.
Informed Consent and Limits of Confidentiality

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You understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without your written permission. (This release is available in Dr. Koser's office or may be completed with any individual whom you wish to give such access, and then provided to Dr. Koser.) The only exceptions to this policy are rare situations in which Dr. Koser is required by law to release information with or without your permission. These are:

1. if there is evidence of abuse of children or abuse to the elderly;
2. if Dr. Koser judge that your are in danger of harming yourself or another individual;
3. if Dr. Koser determines that my child is in danger of harming their self or another;
4. if my or my child's records are required by court order.

In the rare event of any of these situations, Dr. Koser would attempt to discuss his intentions with you before any action is taken, and he would limit disclosure of confidential information to the minimum necessary to insure safety.

You understand that if Dr. Koser deems that additional or alternative testing to be necessary, the reasons for this testing will be explained to you and Dr. Koser will advise you of any additional costs. You understand that you have the right to discontinue the evaluation process at any time. However, you also understand that Dr. Koser may be unable to provide feedback of the test results if testing is terminated, and that you will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.

By your signature below, you acknowledge that you consent to a psychological evaluation by Dr. Koser at The Spectrum Center, that you have been informed of the policies regarding evaluations, have read the 6-page consent form, and that you agree to all of the payment arrangements outlined in this form. You fully understand my rights and obligations as a client and you freely agree to this assessment.

_____	_____	_____
Signature	Date	(Please print name)

If client is under age 14 and/or for financial responsibility for minors:

_____	_____	_____
Parent Signature	Date	(Please print name)
_____	_____	_____
Parent Signature	Date	(Please print name)
_____	_____	Todd Koser, Psy.D.
Clinician's Signature	Date	(Please print name)

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Amended fees

Due to changes in the evaluation at you request requiring additional testing, extensive collateral interviewing, completion of additional forms, report revisions to support requests for accommodations, or other factors additional fees have been agree to by you in the amount of:

Additional Fee for testing, report writing, or consultations: $_____

By your signature below, you acknowledge that you consent to this change in fees.

_____	_____	_____
Signature	Date	(Please print name)

For financial responsibility for minors:

_____	_____	_____
Parent Signature	Date	(Please print name)
_____	_____	_____
Parent Signature	Date	(Please print name)
_____	_____	Todd Koser, Psy.D.
Clinician's Signature	Date	(Please print name