



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Appointment Date/Time:

Client Registration Form — JIAC

Today's Date:		Name of Clinician:			
CLIENT INFORMATION					
Client's Last Name:	First Name:	MI:	Birth Date:	Age:	Sex:
Street Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:	Social Security #:		
School:	Grade:	Teacher/Counselor:	School District:		
MOTHER OR PRIMARY CAREGIVER'S INFORMATION					
Last Name:	First Name:	MI:	Birth Date:	Social Security #:	
Street Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:			
Relationship to Client:					
FATHER OR PRIMARY CAREGIVER'S INFORMATION					
Last Name:	First Name:	MI:	Birth Date:	Social Security #:	
Street Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:			
Relationship to Client:					

Responsive Centers for Psychology and Learning

CONSENT FOR TREATMENT — TESTING

Welcome to our practice. Please read this document carefully and note any questions you might have so you and your examiner can discuss them. **Once you sign this, it will constitute a binding agreement between you and your examiner.**

NOTICE OF PRIVACY PRACTICES

By signing this agreement, you consent to the use of your personal health information for purposes of diagnosis, treatment planning, payment, or health care, according to the [Notice of Privacy Practices](#) posted on the Responsive Centers' website and provided at the Responsive Centers' office.

TESTING

Psychological and psycho-educational testing varies, depending on the referral concerns to be addressed, the referral source, and the age and ability of the client. There are a number of different approaches that can be used. Psychological and psycho-educational testing is often voluntary. There are some cases in which it is court ordered and participation is required. All testing requires an active effort on the part of the client for the results to be reliable and valid. The general goals of an evaluation include, but are not limited to, the establishment of a diagnosis, collection of data sufficient to permit case formulation, and to develop a treatment plan. Other goals of an evaluation may include academic considerations, placement, determination of competency, or custody recommendations. Testing may determine the presence of a disorder that has treatment consequence such as learning disabilities or substance abuse disorders.

The evaluation process may require only one session or multiple sessions. It may be conducted solely by one examiner or several may be involved. There is generally a face-to-face interview with the client and often contact with parents, teachers, spouses, physicians, or other collateral resources. Consent is required to speak with collateral resources. The interview base information and that received from collateral resources are integrated

SETTINGS

Evaluations may be conducted in outpatient settings, inpatient settings, partial hospital setting, residential treatment facilities, long-term care facilities or schools. The scope, pace, and depth of the evaluation depends to a large degree on the setting in which the evaluation is being conducted and the patient population being served.

CONFIDENTIALITY

In general, the confidentiality of all communications between you and your examiner is protected by law. Examiners can release information only with written permission, with some exceptions. In some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony.

There are some situations in which your examiner is legally required to take action to protect others from harm, even though that requires revealing some information about you. If your examiner believes that you, a child, an elderly person, or a disabled person is being abused, your examiner is required to file a report with the appropriate state agency.

If your examiner believes that you are a serious threat to another person, your examiner is required to take protective actions, which may include notifying the police, and seeking appropriate hospitalization. If you threaten to harm yourself, your examiner may be required to seek hospitalization or contact a family member or others who can provide protection.

INDEPENDENT PRACTICE

Responsive Centers for Psychology and Learning is an association of independently practicing professionals, which shares certain expenses and administrative functions. While members share a name and office space, they are completely independent in providing you with clinical services and are fully responsible for those services. Any matters concerning your evaluation should be addressed with your examiner first. If the matter is not resolved to your satisfaction, you may contact our executive director.

REQUIRED SIGNATURES

We have read the above information and understand its contents. We give our full consent for treatment. By signing this document, we are also claiming we have the legal right to do so. We have had the opportunity to read and obtain a copy of the Notice of Privacy Practices either at the office or on the website.

Client's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Witness: _____ Date: _____



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Authorization for Release of Information

Name of Parent/Guardian:
Relationship to Adolescent:
Name of Adolescent:
AUTHORIZATION FOR RELEASE
I authorize the release of the psychological assessment conducted by staff at Responsive Centers to: Yes No Juvenile Intake and Assessment Center and partners Yes No Court Services and Community Corrections
REDISCLASURE
I agree that JIAC staff may redisclose this information to pertinent individuals or other professionals involved in the child's current legal proceedings or treatment.
VALIDITY
I understand that this authorization will expire one year from the date of my signature and that I may revoke this authorization by sending written notices to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which has been made in reliance upon this authorization shall not constitute a breach in confidentiality.
Signature: _____ Date: _____ Client/Parent/Guardian



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Agreement to Participate in the Assessment Process

Adolescent

I, (your name) _____ agree to participate in a psychological assessment on (date) _____ and understand that the information obtained will be used to develop a report that will be sent to JIAC. As part of the report, I understand that recommendations will be made to address any mental health problems or other problems that arise during the assessment process.