Welcome to Psychological Assessment Services, LLC

Referral Packet

2380 N. 124th St., Suite 101
Wauwatosa, Wisconsin 53226
Telephone: (414) 443-1773
Fax: (414) 443-1747
E-mail: NealBrey@psychassess.net

Psychological Assessment Services, LLC provides the greater Milwaukee area with wide variety of psychological assessment services to aid in treatment, forensic, educational, and vocational decision-making of clients throughout the life span. Each assessment is individualized to meet the client's specific needs. We provide psychological assessment services for diverse clientele, including individuals who are of varying abilities, including various developmental disabilities, cognitive abilities (intellectual disability to gifted), or physical abilities; socioeconomic status; ethnicities; mental health diagnoses, and/or legal situations. Our office is wheel-chair accessible and located on the Milwaukee County bus line. We provide the following types of evaluations for preschool, school-aged, adolescent, young adult, middle adult, and/or older adult clients:

- Full psychological evaluations, including cognitive, achievement, adaptive, and personality testing
- Specific diagnostic evaluations
- Competency evaluation, as well as competency restoration treatment
- Risk assessments
- Guardianship evaluations
- Disability evaluations
- Not guilty by reason of mental disease or defect (or criminal responsibility) evaluations
- Psychological evaluations for Child in Need of Protection and/or Services (CHIPS) or Juvenile in Need of Protection and/or Services (JIPS) cases for youth and/or parent
- Accommodations of exceptional educational needs (school-age, adolescent, or higher education)
- Trauma evaluations
- Psychological evaluations on potential adoptive parents
- Waiver (or transfer) evaluations
- Evaluations for dispositional or sentencing purposes
- Please inquire about consultative services or other possible evaluations of interest

We provide our services in a professional and sensitive manner. Our office focuses only upon providing assessment services in order to provide the best, unbiased, comprehensive assessment of each client's current treatment needs and strengths. This practice is owned by Karyn L. Gust-Brey, Ph.D., with contract psychologists Amy Gurka, Ph.D.; Ryan Mattek, Ph.D.; and Tetyana Kostyshyna, PsyD. and our Office Manager is Neal Brey.

Karyn L. Gust-Brey, Ph.D. has been a licensed psychologist since 2000. She worked in the Wisconsin Department of Corrections (DOC) Division of Juvenile Corrections (DJC) for 13 years as a psychology intern and a licensed psychologist. She currently works for the Wisconsin Department of Health Services (DHS) where she is a psychology supervisor in the completion of inpatient competency evaluations, competency restoration treatment, and psychological evaluations in an adult forensic program. She also periodically provides psychological services and consultation for youth placed at the institution because of an adjudication of

delinquency. She has taught graduate assessment courses and has supervised practicum students, predoctoral interns, and postdoctoral fellows in assessment. She has been providing outpatient psychological evaluation services to the greater Milwaukee area since 2009.

Amy Gurka, Ph.D. has been a licensed psychologist since 2009. She has worked in private practice and County-based outpatient/ acute inpatient settings since 2005 providing a variety of psychological services to children, adolescents, and adults. She was an intern through the Division of Juvenile Corrections (DJC). She has also worked for the Waukesha County Department of Health Human Services and the Wisconsin DHS.

Ryan Mattek, Ph.D. has been a licensed psychologist since 2014. He has worked in the Wisconsin DHS where he completed inpatient competency evaluations, competency restoration treatment, and psychological evaluations in an adult and juvenile forensic program. He currently works for the Wisconsin DHS where he completes forensic treatment evaluations for civilly-committed adult sex offenders.

Tetyana Kostyshyna, PsyD. has been a licensed psychologist in Wisconsin since 2016. She is also a licensed clinical psychologist, clinical professional counselor, and sex offender evaluator in the state of Illinois. She completed an APA-accredited internship at the Minnesota Department of Human Services as well as a formal post-doctoral fellowship in forensic psychology at the Wisconsin DHS. She has worked with juveniles and adults in inpatient, outpatient, and transitional settings, providing treatment, evaluation, and consultation services to courts as to treatment progress, competency to stand trial, general psychological functioning, disability, legal guardianship, and optimal placement. Dr. Kostyshyna is fluent in English, Russian, and Ukrainian, and can provide forensic and clinical services in these languages as needed.

To make a referral for psychological evaluation or competency restoration treatment services, please submit the following to:

Psychological Assessment Services, LLC
Attn: Neal Brey, Office Manager
2380 N. 124th St., Suite 101
Wauwatosa, WI 53226

Or fax to 414-443-1747

Or email to NealBrey@psychassess.net

1. The informed consent form (signed by the client if over age 18/is own guardian OR the client's parent or guardian if under 18/has a guardian);
2. The release of information form: Please include the name(s) of anyone the client is working with on a regular basis (signed by the client if over age 18/is own guardian OR the client's parent or guardian if under 18/has a guardian);
3. The Psychological Assessment Services, LLC fee policy form (signed by the individual responsible for payment, either the client or parent/guardian OR the referring individual or agency);
4. The referral form; and
5. Any other information that would be of benefit in answering the referral question, such as delinquency petitions, criminal complaints, court reports, past psychological evaluations, plans of care, school records, and/or other supporting documents.

Once the referral packet is complete (i.e., pages 4-10 of this packet), Psychological Assessment Services, LLC will contact the *referring individual* to discuss how he/she would like to proceed with the scheduling of the appointment (i.e., scheduled through the referral source OR the client or client's parent, guardian, or caregiver).

If there are any questions or concerns, please contact our Office Manager, Neal Brey, at 414-443-1773. Thank you for your interest in our services. We appreciate the opportunity to work with you!

Sincerely,
Drs. Gust-Brey, Gurka, Mattek and Kostyshyna

Informed Consent Form for Psychological Assessment Services, LLC

Client Name: _____ Client's Date of Birth: _____

The purpose of this form is to provide our clients with specific information regarding the psychological assessment and competency restoration services that they will receive at Psychological Assessment Services, LLC. This agency offers both written and verbal information to our clients. Please ask your psychologist or therapist for any clarification regarding your assessment and/or competency restoration treatment.

The psychologist will be administering a battery of tests and clinical interview to help develop a comprehensive and thorough understanding of the referral concern. A psychological evaluation report will be written documenting the findings, diagnosis, and recommendations for treatment. As long as this evaluation was not court-ordered, the client or his/her parent/legal guardian may release this report to others by completing a release of information form. The client or his/her parent/legal guardian will receive a copy of this report as long as the report was not court-ordered. They can request a verbal explanation of the results by the psychologist.

The following applies if you have been referred to participate in this evaluation to address issues relevant to a court case. If this evaluation was court-ordered, a report will be written that will be shared with the Court, District Attorney, Defense Attorney, and any relevant Social Services Agency. The report will only be released to the individuals listed on the court-order and it is the Court's discretion if the report can be released to any further parties, including the client or his/her parent/legal guardian. If this evaluation was requested by your own Defense Attorney (there is no court-order), the report will be shared with your Defense Attorney to determine whether he/she will submit the report to the Court. In court cases, it is possible that the psychologist may be subpoenaed related to these matters and required to provide testimony in court.

If you are participating in competency restoration treatment, the therapist or psychologist will provide information regarding the benefits of treatment, potential risks of treatment, how treatment will be delivered, and alternative treatment options.

I have been provided with the opportunity to discuss any concerns that I may have regarding my psychological evaluation and the privacy of my health information. I understand that my treatment information is confidential unless I am completing a court-ordered evaluation or treatment and there is a court-order that a report must be released to the Court, District Attorney, and Defense Attorney.

My signature on this form also indicates that I have received a copy of the privacy practices and grievance procedures of Psychological Assessment Services, LLC. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Psychological Assessment Services, LLC, of my rights with respect to my health information, and how to use the grievance process.

_____ _____

Client Date

_____ _____

Legal Guardian/relationship to client Date
(necessary if client is under age 18)

Release of Information Form for Psychological Assessment Services, LLC

Client Name: _____

Date of Birth: _____

Parent's or Guardian's Name:_____

I understand that my treatment information is confidential unless I am completing court-ordered evaluation or treatment and there is a court-order that a report must be released to the Court, District Attorney, and Defense Attorney. I am under no obligation to sign this form. I authorize Psychological Assessment Services, LLC to do the following with my treatment information:

☐ Release my treatment information or psychological evaluation report to the following individuals or agencies:

_____

_____

☐ Receive treatment information from the following individuals or agencies

_____

_____

I understand that this authorization will expire in one year unless a different date is indicated.
Adjusted date: _____

I understand that the treatment information being disclosed includes any information from birth to the end of my treatment unless otherwise specified below.
Time Period: _____

I understand that I am authorizing any of my treatment information to be disclosed unless otherwise specified below:
Specific information disclosed: _____

_____

_____ _____
Client's Signature (if 14 years old or older) Date

_____ _____
Guardian's Signature (if client is under 18) Date

_____ _____
Psychologist's or Therapist's Signature Date

Financial Agreement Form for Psychological Assessment Services, LLC

Client Name: _____ Client's Date of Birth: _____

The purpose of this form is to provide the client with information regarding fees for services.
Following is a list of services and fees (please check the services and reimbursement agreed upon):

Psychological testing, scoring, interpretation, report writing, feedback, and testimony:

☐ $200 per hour or the insurance/referral agency's regular reimbursement for this service (note: _____)

Consultation services:

☐ $100 per hour or the insurance/referral agency's regular reimbursement for this service (note: _____)

Competency restoration treatment:

☐ $90 per hour or the insurance/referral agency's regular reimbursement for this service (note: _____)

Psychological Assessment Services, LLC will bill our clients or the referring agencies at the agreed upon rate according to this financial agreement. Psychological Assessment Services, LLC will bill services through private insurance, medical assistance, and/or directly to our clients. In the event that a client is uninsured and/or unable to pay the agencies rates, a sliding fee schedule will be used to determine a fee for services. The agreed upon price will be recorded on this form.

Plan 1: Psychological Assessment Services, LLC will bill the following agency/individual for services:

_____

Plan 2: In the event that "Plan 1" changes or does not cover the entire cost of services, Psychological Assessment Services, LLC will bill the following agency/individual for services:

_____

Sliding Fee Clients:

☐ Based on my annual income of _____, and the number of people supported by this income, I agree to pay _____. I have provided a copy of my most recent pay stub.

Psychological Evaluations:
For clients involved in psychological evaluation, the details regarding time (direct and indirect service) are as follows:

_____

By signing this financial agreement, I understand that I am responsible for payment of services as outlined above. I authorize Psychological Assessment Services, LLC to release any information necessary to process my insurance claims.

_____ _____
Individual responsible for payment Signature Date

_____ _____
Psychologist's or Therapist's Signature Date

Referral Form for Psychological Assessment Services, LLC

Person Completing This Form

Name: _____

Address: _____

_____

Phone Number: _____

E-mail: _____

Relationship to Client: _____

Client Information

Client Name: _____

Date of Birth: _____ Sex: _____

Current Address: _____

_____

Phone Number: _____

Primary Language Spoken: _____

Individuals Residing in Client's Household (if not in residential treatment or group home placement):

_____

_____

Caregiver's Name (if different from above): _____

Parent or Guardian's Name (if different from above): _____

Parent or Guardian's Address (if different from above): _____

_____

Parent or Guardian's Phone Number (if different from above): _____

E-mail: _____

What specific question(s) do you want answered by this evaluation? _____

_____

_____

_____

Briefly describe the client's current difficulty or difficulties. How long has this are been a concern? What seems to help or make this concern worse? _____

_____

_____

_____

_____

What is the client's current psychotropic medication type and dose? Please provide a description of current treatment, such as therapy or other services. _____

_____

_____

_____

What has been this client's past therapy, treatment (including inpatient hospitalizations), or medications? ___

_____

_____

_____

Please describe the client's family history, including any mental health concerns present or losses within the family. _____

_____

_____

_____

_____

Please describe the client's social, peer, and romantic (sexual) relationships, including any sexualized behavior (if present). _____

_____

_____

_____

_____

What is the client's academic or vocational performance? Please include any history of special education, as well as any behavioral issues in school. _____

_____

_____

_____

_____

What is the client's legal history? Please include any current or past charges and tickets. _____

_____

_____

_____

Describe any substance use history or treatment. _____

_____

_____

_____

Describe the client's current and past medical history. Please include any knowledge on the attainment of developmental milestones. _____

_____

_____

_____

If the client has had previous psychological evaluations, please include when these evaluations were completed, by who, and any relevant findings. _____

_____

_____

_____

_____

What has been this client's past diagnoses through other sources than psychological evaluations? _____

_____

_____

Does the client have any history of physical/sexual abuse or neglect? If so, please describe.

_____

_____

_____

Please provide any information as to the client's attempts of self-harm, self-injurious behavior, and/or attempts to harm others. _____

_____

_____

_____

Please describe relevant information as to the client's interests, abilities, and strengths. Also include any spiritual beliefs of importance. _____

_____

_____

_____

_____

Thank you for your completion of this referral.