Psychological Assessment Services, LLC

2380 North 124th Street, Suite 101
Wauwatosa, WI 53226

Phone: 414.443.1773 Fax: 414.443.1747 email: Nealbrey@psychassess.net

Psychological Assessment Services, LLC Referral Packet

2380 N. 124th St., Suite 101
Wauwatosa, Wisconsin 53226
Telephone: (414) 443-1773
Fax: (414) 443-1747
General 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. Evaluations are provided in English and/or Spanish. 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 evaluations, as well as competency restoration treatment for juveniles
- 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
- Parental capacity evaluations for Child Protective Services (CPS)-related situations
- Autism spectrum disorder evaluations, including administration of the Autism Diagnostic Observation Schedule (ADOS)
- Attention-deficit/hyperactivity disorder evaluations, including administration of the Test of Variable of Attention (TOVA)
- Accommodations of exceptional educational needs (school-age, adolescent, or higher education)
- Trauma evaluations
- Waiver (or transfer) evaluations from juvenile to adult court
- Reverse waiver 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 and competency restoration treatment 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.

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 has worked for the Wisconsin Department of Health Services (DHS) since 2013, where she is currently 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. She has experience in expert witness testimony.

Rachel Reinders-Saeman, Ph.D., received her license as a psychologist in 2019. She has been a licensed professional counselor since 2017. She has worked in community-based clinics as well as inpatient facilities. She is fluent in Spanish, and she is able to conduct psychological evaluations with Spanish-speaking individuals and families. She completed her internship at Mendota Mental Health Institute, and she is currently an Assistant Professor of Psychology at Alverno College.

Madeline Bliske (she/her/ella), Ph.D. is a post-doctoral fellow in school psychology. Throughout her practicum placements, she has gained experience providing both individual and group therapy as well as completing educational and psychological evaluations within Milwaukee Public Schools, community mental health, and private practice settings. Madeline graduated from the University of Wisconsin-Milwaukee doctoral School Psychology program and completed her internship at WellPower, a community mental health organization, through the University of Denver Graduate School of Professional Psychology Consortium. She has experience conducting evaluations with bilingual (English/Spanish) children and adolescents, completing neurodevelopmental assessments (i.e., attention-deficit/hyperactivity disorder, autism spectrum disorder), and using a therapeutic assessment approach to offer a strengths-based evaluation and recommendations.

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: (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/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, 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,
Dr. Gust-Brey

Psychological Assessment Services, LLC Privacy Notice & Grievance Procedure

The purpose of this document describes how medical information about you may be used and disclosed and how you can get access to this information. It also provides an overview the grievance procedure. **Please review it carefully**. Protected Health Information (PHI) includes personal information relating to your past, present, and future medical or mental health condition. In accordance with the Privacy Rule and Health Insurance Portability and Accountability Act of 1996 (HIPPA), Psychological Assessment Services, LLC has established a policy to guard against unnecessary disclosure of your health information. This notice is effective September 1, 2014.

Psychological Assessment Services, LLC may use and disclose health information about you in the following ways:

- **To Provide Psychological Assessment or Competency Restoration Treatment**
  Psychological Assessment Services, LLC may use your PHI to provide care to you and disclose your health information to others who provide care to you. This may include consultation or supervision with therapists, mental health providers, or treatment team members, upon completion of a release of information form. This consultation or supervision would occur to assist in determining the best treatment options for you.
- **To Obtain Payment**
  Psychological Assessment Services, LLC may include your PHI in invoices to collect payment from third parties for the services you receive. Psychological Assessment Services, LLC may be required by your health insurer to provide information regarding your health care status to determine eligibility of benefits, receive prior authorization, and reimbursement for services.
- **To Conduct Health Care Operations**
  Psychological Assessment Services, LLC may use and disclose your PHI for its own operations in order to facilitate business activities including, but limited to, quality assessment, employee review, program development, internal training programs, licensing and certification, general administrative duties, and competency restoration treatment outcome research.
- **When Legally Required**
  Psychological Assessment Services, LLC may have to make disclosures of your PHI when required by state or federal law without your authorization. Information is disclosed to legal authorities for the purpose of maintaining compliance with the Privacy Rule. Psychological Assessment Services, LLC also has to report to legal authorities suspected child abuse or neglect, domestic violence, possible attempts or thoughts of endangering self or others, or a response to a court order. Additionally, Psychological Assessment Services, LLC is required to disclose your PHI if you are a victim of a crime or I order to report a crime.
- **With Authorization**
  Psychological Assessment Services, LLC will not use or disclose your PHI not specifically permitted by law unless given your authorization.

Client's right in regard to PHI:

- **Right to Request Restrictions**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to request restrictions on certain uses and disclosures of your PHI. Our clients have the right to request a limit on Psychological Assessment Services, LLC disclosure of client's PHI to someone who is involved in client care or payment. However, Psychological Assessment Services, LLC is not required to agree to the client's request. Clients who wish to make a request for restrictions should contact Psychological Assessment Services, LLC at (414) 443-1773.
- **Right to Receive Confidential Communications**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to request their psychologist communicate with them in a certain way to protect confidentiality. For example, the client may ask that Psychological Assessment Services, LLC only conduct communications pertaining to clients PHI with them privately with no other family members present.

- **Right to Inspect and Copy your PHI**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to inspect and copy their PHI, including billing. However, this right does not necessarily apply to assessment/treatment notes or information gathered for judicial procedures. In the event that the client would like to inspect their PHI, they should arrange a meeting with their psychologist to review their records in our offices. Psychological Assessment Services, LLC may charge a reasonable fee for copying and assembling costs associated with this request.
- **Right to Amend Your PHI**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to amend their PHI if they believe that information is incorrect or incomplete. This request may be made as long as this information is maintained by Psychological Assessment Services, LLC. Psychological Assessment Services, LLC may deny the request if it is not in writing, does not include a reason for the amendment, if the records were not created by Psychological Assessment Services, LLC, if the records are not part of Psychological Assessment Services, LLC records, if the request includes a part of the record that client is not permitted to inspect or copy, or if in the opinion of Psychological Assessment Services, LLC the records containing your PHI are accurate and complete.
- **Right to an Accounting of Your PHI**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to request an accounting of disclosures of client's PHI made by Psychological Assessment Services, LLC for certain purposes which may include disclosures required by law and disclosures made for research. This request for an accounting must be made in writing and should specify the time period for the accounting which cannot include dates prior to September 1, 2014. Psychological Assessment Services, LLC will provide the first accounting of a request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable fee.
- **Right to a Paper Copy of this Notice**
  Psychological Assessment Services, LLC privacy policy provides our clients with the right to receive a paper copy of this notice at any time, even if they have received this notice previously.

Responsibilities of Psychological Assessment Services, LLC:
Psychological Assessment Services, LLC is required by law to maintain the privacy of client's PHI and to provide clients with this notice of our duties and privacy practices. Psychological Assessment Services, LLC is required to abide by the terms of this notice and reserve the right to change the terms of this notice at any time. If Psychological Assessment Services, LLC makes any changes to this notice, we will provide a copy of the revised notice to our clients.

Grievance Procedures
Psychological Assessment Services, LLC clients have the right to express complaints to Psychological Assessment Services, LLC or to legal authorities if they believe that their rights have been violated. Psychological Assessment Services, LLC encourages our clients to express any concerns they may have regarding the privacy of their PHI. Our clients will not be retaliated against in any way for filing a complaint. Psychological Assessment Services, LLC encourages clients to express their concerns to their psychologist an initial stage of resolution. In the event that the client's concerns are not resolved, the client should express their concerns in writing to the owner of Psychological Assessment Services, LLC within 45 days of becoming aware of the problem.

Contact Person
Psychological Assessment Services, LLC has designated Karyn L. Gust-Brey, Ph.D. as its contact person for all issues regarding client privacy and your rights under the Federal privacy standards. Karyn L. Gust-Brey, Ph.D. can be contacted at Psychological Assessment Services, LLC at (414) 443-1773.

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 postdoctoral fellow for any clarification regarding your assessment and/or competency restoration treatment. Please note that the work of postdoctoral fellows are not licensed and are supervised by a licensed psychologist.

We will be administering a battery of tests and conducting a 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 us.

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 that is listed on the court-order. 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 we may be subpoenaed related to these matters and required to provide testimony in court.

If you are participating in competency restoration treatment, the postdoctoral fellow 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 (included in this referral packet). 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 (sign if age 14 and up) Date

_____ _____

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

_____ _____

Psychologist's or Postdoctoral Fellow's Signature Date

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 competency restoration 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: **(INCLUDE NAME AND ADDRESS FOR THE REPORT TO BE SENT)**

_____

_____

_____

_____

☐ Receive treatment information from the following individuals or agencies: **(INCLUDE CONTACT INFO)**

_____

_____

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

I understand that the 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 information to be disclosed unless otherwise specified below:
Specific information disclosed:

_____

_____ _____

Client (sign if age 14 and up) Date

_____ _____

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

_____ _____

Psychologist's or Postdoctoral Fellow'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:
☐ $125 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.
Please list insurance and member number:

_____

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 Postdoctoral Fellow'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: _____ Race/Ethnicity: _____

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: _____

1. What specific question(s) do you want answered by this evaluation? Briefly describe the client's current difficulty or difficulties. How long has this area been a concern? What seems to help or make this concern better/worse? _____

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

3. What has been this client's past therapy, treatment (including inpatient hospitalizations), or medications? What age did mental health treatment begin? _____

4. Please describe the client's family history, who raised the client, how many siblings does the client has, include any mental health concerns present or losses within the family. _____

5. Please describe the client's social relationships, including any friendships, romantic, or sexualized behavior (if present and of an age). _____

6. What is the client's academic and/or vocational performance? Please include any history of special education, as well as any behavioral issues in school. Has the client been in the military or received social security?

7. What is the client's legal history (if of an age for such behaviors)? Please include any current or past charges and tickets.

8. Describe any substance use history or treatment (if of an age for such behaviors).

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

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

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

12. Does the client have any history of physical/sexual abuse or neglect? Are there any other traumatic events, such as witnessing violence, domestic violence, being the victim of a crime, other trauma. If so, please describe. _____

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

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

15. Is there any other information that we should know for this evaluation? _____

Thank you for completing this referral; only pages 5-11 need to be submitted.