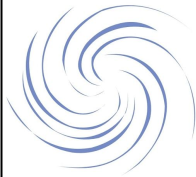

Lakeside Psychological Evaluations and Family Consulting, LLC
740 Pilgrim Parkway Suite 103
Elm Grove, WI 53122
Phone (414) 514-8155 Fax (262) 782-7815
www.lakesidepsychological.com

# Psychological Evaluation Referral Form

Please complete every question on this referral form. Once complete, please forward all supporting documentation (referral form, consent, financial agreement, release of information, past evaluations) to Dr. Heidi Gahr at hgahr@lakesidepsychological.com or fax (262) 782-7815. Following review, Dr. Gahr will contact the individual or agency who made the referral to schedule an appointment.

**Referral Source:**

Name:__________________________________________________________

Phone Number:_____________________ Email address:____________________

Name/Address of Agency: ____________________________________________

Relationship to the client: ___________________________________________

**Client information:**

Name: __________________________________________________________

DOB: _____________________ Sex: __________

Parent(s)/Legal Guardian(s) Name(s):____________________________________

Parent(s)/Legal Guardian(s) Phone Number(s): _____________________________

______________________________________________________________

Parent(s)/Legal Guardian(s) address: ____________________________________

______________________________________________Email:____________________

Caregiver(s) Name and Address (if different from above): _________________________

______________________________________________Email:____________________

Caregiver(s) Phone Number (if different from above): ____________________________

What specific questions do you want answered by this evaluation?_________________

________________________________________________________________________

________________________________________________________________________

Client's interests, strengths, extracurricular activities: ____________________________

________________________________________________________________________

________________________________________________________________________

List significant developmental issues (milestones, medical problems, etc.)

________________________________________________________________________

________________________________________________________________________

Client's current grade and school: ____________________________________________

Academic functioning/specific difficulties: ______________________________________

________________________________________________________________________

Specific IEP information (if applicable): _______________________________________

________________________________________________________________________

Behavioral concerns: _____________________________________________________

________________________________________________________________________

Emotional/Mood concerns: ____________________

Social concerns: ____________________

Sexualized behavior concerns: ____________________

Current or past trauma (physical, sexual, emotional, other): ____________________

Current and past legal issues (including charges and status of charge): ____________________

Name and contact information for legal issues (Judge, ADA, HSW, attorneys, etc) if applicable: ____________________

Medication/dose/treating psychiatrist: ____________________

Past medications: ____________________

Treatment history (including therapist, length of treatment, hospitalizations):

______________________________________________________________________

______________________________________________________________________

Current and past diagnoses: ____________________________________________

______________________________________________________________________

Current family dynamics (family structure, quality of relationships, etc): ____________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Family psychiatric history: ______________________________________________

______________________________________________________________________

Past psychological evaluations (date, clinician, outcome): ______________________

______________________________________________________________________

***Please provide a copy of all previous evaluations at the time of referral***

**Additional Information:** ____________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

# Informed Consent and Privacy Policy

The purpose of this form is to provide clients with specific information regarding psychological evaluations and/or consultation services they receive at Lakeside Psychological Evaluations and Family Consulting, LLC. Information is provided to clients in both written and verbal forms. If you have questions regarding your rights as a client, please ask and understand the answers prior to signing this form.

A psychological evaluation involves clinical interviews as well as the administration of various tests and measures. The results are then integrated into a report for the purpose of diagnostic clarification and treatment recommendations related to the referral. For court ordered evaluations, the report will be forwarded to all relevant court officials upon completion. For non-court ordered evaluations, the report will be released to the client's legal guardian(s) as well as to individuals or institutions that the legal guardian(s) identified and provided written permission.

Consultation may include intakes, psychotherapy, feedback sessions, or services related to families who are in the process of restructuring due to divorce.

Lakeside Psychological Evaluations and Family Consulting, LLC will discuss the potential benefits, risks, approach, and alternative options prior to the onset of evaluation or consultation services.

Clients and/or legal guardian(s) have the right to withdraw consent, at any time, through a written statement. Consent to receive services through Lakeside Psychological Evaluations and Family Consulting, LLC remains in effect for one year unless consent is withdrawn prior.

All information obtained by Lakeside Psychological Evaluations and Family Consulting, LLC will remain confidential, with the following exceptions:

- To obtain payment from a third party
- When legally required due to suspected safety issues (self or other), abuse, or neglect
- Court ordered evaluations or treatment
- If a release of information if obtained

By signing this form, I am indicating that:

- I am giving my permission to receive services at Lakeside Psychological Evaluations and Family Consulting, LLC
- I understand that I can withdraw my consent at any time
- I understand the potential risks and benefits of psychological evaluations and consulting services as well as the approach to services and alternative options
- I have been given the opportunity to ask questions and express concerns regarding my private health information, confidentiality, and treatment
- I understand my rights to confidentiality as well as how my private health information will be used
- *I received a copy of the "Client Rights and the Grievance Procedure for Community Services" in accordance with the policies of Lakeside Psychological Evaluations and Family Consulting, LLC*

| | |
|---|---|
| Client | Date |
| Legal Guardian/relationship to client<br>(necessary if client is under age 18) | Date |
| Heidi Gahr, Psy.D.<br>Licensed Clinical Psychologist | Date |

# Financial Agreement Form

The purpose of this form is to provide specific information to the client regarding fees for services.  The following is a list of services and fees:

- ☐ Psychological Evaluations: $200/hour
- ☐ Psychotherapy (50 minute session):  $150/hour
- ☐ Consultation Services (Child Specialist): $175/hour (not subject to insurance)
- ☐ Feedback Session (50 minute session): $100/hour

*The client will be billed at these rates or at the insurance/agency contracted rates

Primary insurance:  Lakeside Psychological Evaluations and Family Consulting, LLC will bill the following for payment of services:

_______________________________________________________________

Secondary insurance:  If the primary insurance does not cover the entire cost of the service, Lakeside Psychological Evaluations and Family Consulting, LLC will bill the following for payment of services:

_______________________________________________________________

*Lakeside Psychological Evaluations and Family Consulting, LLC reserves the right to use a collection agency for unpaid services if alternative arrangements are unsuccessful
*All co-pays and out of pocket payments are due at the time of service

By signing this agreement, I understand that I am responsible for payment of services as outlined above.  I authorize Lakeside Psychological Evaluations and Family Consulting, LLC to release my private health information to process insurance claims.

________________________________ ________________
Client/Legal Guardian Date

________________________________ ________________
Heidi Gahr, Psy.D. Date
Licensed Clinical Psychologist

# Release of Information

Client Name: ________________________________DOB:_________________

Parent(s) or Legal Guardian(s):

_______________________________________________________________

I understand that my private health information (evaluation, consultation, treatment) is confidential unless I am court ordered to undergo a psychological evaluation or treatment. I authorize Lakeside Psychological Evaluations and Family Consulting, LLC to do the following with my private health information:

*Release my private health information to the following individuals or agencies:*

________________________________________________________________

________________________________________________________________

________________________________________________________________

*Exchange my private health information with the following individuals or agencies:*

________________________________________________________________

________________________________________________________________

________________________________________________________________

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

I understand that the private health information being disclosed includes any and all information unless otherwise specified:

________________________________________________________________

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

_______________________________ ________________
Guardian's signature (if client is under 18) Date

______________________________ ________________
Heidi Gahr, Psy.D. Date
Licensed Clinical Psychologist