Mariam A. Mott, Ph.D.

Licensed Psychologist #16181

Office: (949) 858-MOTT Fax: (949) 858-6986 e-mail: drmott@drmott.com web site: www.drmott.com

Child's name:_____ **Date of Birth:**_____

PARENT ASSESSMENT AGREEMENT

This document contains important information about my professional services and business policies. Please read this information carefully, and make note of any questions you have so they can be discussed with me.

BENEFITS, RISKS, AND ALTERNATIVES TO TREATMENT

You have been given this document because you are requesting an assessment (also known as evaluation or testing) for _____ (name of child). Testing can help us to understand cognitive, academic, attentional, behavioral, and/or emotional strengths and needs and can facilitate recommendations to help the child meet his or her full potential.

I will select which tests to administer based on the reasons your child was referred for testing. Examples of tests that MAY be administered include (but are not limited to): cognitive/intelligence tests; achievement tests (to measure mastery of academic skills); neuropsychological tests (e.g., memory, abstract reasoning, etc.); behavioral inventories (e.g., to assess ability to focus and concentrate, impulsivity, etc.); and tests that measure personality and emotional functioning. Additional information may be obtained from you, your child's teachers, and/or your child via interviews, observations, and/or questionnaires.

There are several potential benefits of completing a thorough assessment, including (but not limited to): understanding the probable causes of difficulties your child may be experiencing; determining what (if any) additional interventions are needed (e.g., tutoring, developing an Individualized Educational Plan (IEP), behavioral/ psychological support, medication, etc.); assisting the teacher and other school staff in working with your child; and assisting you in making informed educational decisions for your child.

Some risks do exist, however. For example, in rare cases, the test results may not accurately reflect your child's abilities (e.g., due to motivation, fatigue, or illness during testing), or the diagnostic impressions may not be complete or entirely accurate. If this is the case, cautionary statements will be included whenever possible in the written report. Also, your child may experience minor discomfort during the actual testing (e.g., fatigue, frustration, anxiety, etc.). You and/or your child may be unhappy with the test results (e.g., if they indicate deficiencies in certain abilities). It is conceivable (although unlikely) that the test results and/or diagnostic impressions will produce unfair bias among professionals who receive the written report.

It is important for the school to be aware of your child's strengths and areas of development to best meet your child's individual needs. Please initial next to the appropriate statement:

_____ I grant permission for my child's school to receive a copy of the report.

_____ I do NOT grant permission for my child's school to receive a copy of the report.

Please be aware that I will not release a copy of your child's report to anyone other than you without signed permission of BOTH parents on a separate Release of Information Consent Form.

If you have questions about the services being provided at any time, please feel free to ask for clarification. If for any reason you wish to seek services elsewhere, I will help you locate another mental health professional upon your request.

HOURS/AVAILABILITY/CONTACT INFORMATION

I am available to conduct assessments during normal business hours Monday through Friday, although mornings are preferable. Exceptions to typical testing times can be arranged with advanced notice. Assessments will be conducted at my office:

31371 Rancho Viejo Road, Suite 203
San Juan Capistrano, CA 92675
(949) 858-MOTT (6688)

Test sessions will typically last 90 minutes to 2 hours, and multiple sessions are usually needed to complete the assessment. Should you need to change your scheduled appointment time, please call me AT LEAST 24 HOURS IN ADVANCE. I can also be reached via e-mail at drmott@drmott.com, although the confidentiality of e-mail communications cannot be guaranteed.

CONFIDENTIALITY AND RECORD KEEPING

The confidentiality of communications between you, your child, and myself is important and is generally legally protected. Normally, information can be released only with your written permission. If you grant signed permission (via a Release of Information Consent Form) for the school to receive a copy of the report, it is likely that the contents will be discussed with educators and other professionals who work with your child on a "need to know" basis. Although there is every expectation that your school will protect the confidentiality of the report, I cannot be held responsible for a breech of confidentiality by school personnel.

Please note that there are some important exceptions to the overall legal and ethical requirement of confidentiality. For example, reports are required in suspected cases of abuse of a child, elderly or disabled person, as well as in situations where a person may be a danger to him/herself or another. Also (upon parental request), I may furnish the information necessary to obtain reimbursement when a third party is expected to pay for some part of the costs of services.

In most legal proceedings, the therapist-client privilege protects information about your child's assessment (although certain court proceedings, actions before the Board of Psychology, or other illegal activity may limit the ability to maintain confidentiality). When the assessment is done for another party, or as part of a court procedure, the information may be released. By signing this form, you agree that you will not attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, neither of you will ask me to testify in court, either in person or by affidavit. You also agree

to instruct your attorney not to subpoena me or to refer in any court filing to anything I have said or done. Please note that I am ethically bound not to give my opinion about either parent's custody or visitation suitability. In the case of custody disputes, if there is a court appointed Evaluator, Guardian Ad Litem, or Parenting Coordinator, I will provide information as necessary (if appropriate Releases are signed and a Court Order is provided), but I will not make any recommendation about the final decision.

Occasionally, I may find it helpful to seek consultation with other professionals regarding your child. Such consultations are also legally bound by laws of confidentiality, and I will make every effort to protect confidentiality when discussing your child's case.

RELEASE OF INFORMATION

Most insurance agreements require you to authorize me to provide information, including the resulting diagnosis, a copy of the report, or in rare cases, even a copy of the entire record. Once the insurance company has this information, I will have no control over what they do with it.

In order to more completely assess your child, it may be important to obtain records from previous treating professional(s). Your agreement to the release of previous treatment records may assist in the assessment of your child. **Please provide me with information on previous services received by your child and/or your family.**

My child has been previously evaluated by a medical and/or mental health professional (check one):
___ no
___ yes (list details): _____

Please be aware that I will not contact any professional who has previously assessed your child without signed permission of BOTH parents on a Release of Information Consent Form.

You will receive a copy of your child's report, which will summarize his/her performance on the tests, provide clinical impressions and/or diagnoses, and include recommendations. You are also entitled to review your child's complete record if you wish. However, professional records can be misinterpreted and/or upsetting, therefore it is recommended that if you wish to see your child's complete record, you review it with me so you can discuss any questions you may have. In rare cases, I may determine that reviewing your child's entire record would have negative consequences to you and/or your child. In that case, I will provide the record to an appropriate mental health professional of your choice.

FEES AND PAYMENT

I am "fee for service," meaning that you are responsible for payment and I will not bill your insurance company directly. However, I will provide you with an invoice ("super bill") that includes the necessary CPT codes, diagnostic codes, and NPI number that you can submit to your insurance. **I urge you to contact your insurance company in advance of our appointment to determine whether they will cover testing, and if so, under what conditions**. Please note that **some insurance companies require "preauthorization"** in order to provide any reimbursement for services rendered.

I charge a "flat fee" for assessments, since it has been my experience that this policy is fairer to my clients. The estimated fees on the attached sheet includes: the cost of the initial (telephone) consultation; records review; conducting the actual tests (which may take longer than estimated, depending on the child); scoring and interpreting the results; writing the report; and meeting with parents to review the report (if requested). Meetings with the child's school (if requested by parents) and/or classroom observations that are not part of an assessment are billed at a flat rate of **$300.00.** The total cost of your child's assessment will depend on the nature of the referral questions and the extensiveness of the testing being conducted (see attached sheet for estimated costs). I will discuss the specifics of your child's testing with you in advance, and will estimate the cost for the assessment. In the unlikely event that extensive and/or ongoing services are required, those services will be billed to you at the rate of **$150.00 per hour**.

You may pay for services in advance or at the time of service. ***A minimum of 50% of the estimated cost is due at the time of service. The remaining 50% is due upon receipt of the completed report.*** Please be aware that ***you are directly responsible to pay me the fees to which we have agreed.*** Any exceptions to this payment policy (e.g., a payment schedule in the case of financial hardship) can be discussed with me in advance. ***It is your responsibility to check with your insurance carrier to determine whether or not they cover psychological assessments***. I will not bill your insurance company, but will provide you with an invoice for you to submit for reimbursement after payment to me is received. There is a $15.00 charge on all returned checks. Delinquent accounts will be referred for collection (the minimum amount of information necessary will be released in order for the collection agency to secure payment).

ACKNOWLEDGEMENT

I have reviewed the information in this agreement, and have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to have my child participate in the assessment.

Signature of Parent/Guardian (MATERNAL)	Date
Name (Please Print)	Relationship to youth
Signature of Parent/Guardian (PATERNAL)	Date
Name (Please Print)	Relationship to youth

NOTICE: The Department of Consumer Affairs receives questions and complaints regarding the practice of psychology. If you have any questions or complaints, you may contact this department by calling: (866) 503-3221 or (916) 574-7720 or by email (bopmail@dca.ca.gov) or by writing to the following address: Board of Psychology / 1625 North Market Street, Suite N-215 / Sacramento, CA 95834.

Updated 4/25/18

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Child's name:_____ **Date of Birth:**_____

CHILD ASSESSMENT AGREEMENT

I have been asked to meet with Dr. Mott so that we can understand the way I learn best. Dr. Mott and I will be completing several activities together, such as answering questions and solving problems. I know that these activities are made for children of all ages. Even though some of the questions may be easy for me, I know that some of them will be hard. I agree to do my best so that my parents, teachers, and Dr. Mott can work together to help make learning easier for me.

In general, the things I tell Dr. Mott will be private, unless she decides that she must tell someone else. I understand that Dr. Mott's first job is to make sure that everyone is safe. She is required by law and by the standards of her profession to tell others if she thinks that a child or older person is being hurt in some way, or if someone may be a danger to themselves or others. Dr. Mott may decide to tell my parents if I am involved in dangerous activities (e.g., alcohol or drug use, suicidal thoughts, etc.). In most legal proceedings, assessment information is protected. However, information may need to be shared during certain court proceedings.

I realize that my parents will receive a copy of Dr. Mott's report, which will help them understand the ways I learn best and will suggest some ways to help me in school. My parents may decide to give a copy of the report to my school. People who see the report (my parents, teachers, and Dr. Mott) are expected to keep the information private.

_____ _____

Child's Signature Date

_____

Child's Name (Please Print)

Updated 4/25/18

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APPROXIMATE COSTS OF SELECTED TESTS

Listed below are **FLAT FEE** costs for administering, scoring, and interpreting various assessment tools. Additional assessment tools will be used as agreed upon by you and Dr. Mott, and will be billed at the rate of **$150.00 per hour** (as stated in the informed consent). Although the rates listed below are an estimated "flat fee" cost of your child's assessment, your actual cost may vary from this estimate.

❑ Conners' Rating Scales (CRS-3):	
❑ Parent, Teacher, or Youth Self-Report (Long version) (cost is per questionnaire)	$95
❑ Parent, Teacher, or Youth Self-Report (Short version) (cost is per questionnaire)	$ 60
❑ Developmental History Questionnaire ***(required for all assessments)***	$ 75
❑ Devereux SMD (Parent or Teacher Questionnaire) (per questionnaire)	$ 75
❑ Functional Academic Skills Checklist (FASC) (per questionnaire)	$ 45
❑ **NEPSY-II (Neuropsychological Assessment):**	
❑ Attention and Executive Functioning Domain	$350
❑ Language Domain	$225
❑ Memory and Learning Domain	$450
❑ Sensorimotor Domain	$150
❑ Social Perception Domain	$150
❑ Visuospatial Processing	$450
❑ Wechsler Intelligence Scale for Children, 5th Edition (WISC-V)	$650
❑ Wechsler Individual Achievement Test, 3rd Edition (WIAT-III)	$950
❑ **ADHD Assessment** *(includes Developmental History Questionnaire, Conners' Parent, Teacher (and Youth) Rating Scales (Long versions), Devereux SMD, Dyslexia Screening Instrument, observations from teachers, WISC-V, NEPSY-II Attention/Executive Functions subtests, records review, and debriefing meeting with parents)*	$1500
❑ **Psycho-educational Assessment** *(includes Developmental History Questionnaire, Devereux SMD, Dyslexia Screening Instrument, observations from teachers, WISC-V, WIAT-III, records review, and debriefing meeting with parents)*	$1750
❑ **ADHD + Psycho-educational Assessment** *(includes Developmental History Questionnaire, Conners' Parent, Teacher (and Youth) Rating Scales (Long versions), Devereux SMD, Dyslexia Screening Instrument, observations from teachers, WISC-V, WIAT-III, NEPSY-II Attention/Executive Functions subtests, records review, and debriefing meeting with parents)*	$2250
❑ **Classroom Observation, Review of Previous Test Reports (e.g., from the Public School), and/or School Meeting—Flat Fee** *(regardless of time involved; includes travel time to and from the school)*	$300

❑ Additional assessments as needed: (**$150 per hour** for testing, scoring, and interpretation time):

_____ $_____

_____ $_____

TOTAL: $_____

I agree to pay for the services indicated on this assessment price list. **I understand that a minimum of 50% of the estimated amount is due at the time services are received.** ***Please make checks payable to Dr. Mott.***

_____ _____

Signature of Parent/Guardian Date Updated 4/25/18