# Brenner Assessment & Consultation Center

**Forensic & Clinical Services at William James College**
***A program of M. Gorman Psychological Associates***
One Wells Ave, Fourth Floor, Newton, MA 02459
Telephone: 617-323-1735; Facsimile: 617-323-6969

## REGISTRATION INFORMATION -- ADULT

**Name:** _____ **Date of Birth:** ____/____/_____

**Sex:** ☐ **Male** ☐ **Female** **Gender:** _____ **Preferred Pronouns:** _____

**Ethnicity:** ☐ **Hispanic/ Latino** ☐ **Non-Hispanic/ Non-Latino** ☐ **Do Not Wish to Report**

**Select Your Race**: ☐ **White** ☐ **Black or African-American** ☐ **Asian (including South Asian and Japanese)** ☐ **Native Hawaiian/ Pacific Islander**

☐ **Native American/ Alaskan Native** ☐ **Biracial/Multiracial** ☐ **Do Not Wish to Report**

**Identified Country of Origin/ Cultural Background (e.g., Irish, Cuban, Kenyan):**_____

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**Are you under guardianship?** ☐ **Yes** ☐ **No**

**If yes, please fill out guardian contact information below.**
**Guardian name:** _____

**Phone number:** _____ **Address:** _____

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**Address:** _____
**City:**_____ **Zip Code:** _____

**Phone Number(s): Home:** _____**Work:** _____

**Cell:** _____ **E-mail:**_____

***For your privacy, are there any lines where we can leave a message with sensitive information about your assessment?*** ☐ **Home** ☐ **Cell**

**Preferred method(s) of contact:** ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Email**

**Have you received assessment services at the Brenner Center before?:** ☐ **Yes** ☐ **No**

**If yes…**

**What type of service(s) did you receive?** _____

**When did you receive this service(s)?** _____



**Record #**: _____
**Received**: ___/___/_____

**Has your name changed since the last time you were seen at Brenner? ☐ Yes ☐ No**

**If yes, please write your previous name: _____**

**Would you prefer to be tested….? ☐ In-person ☐ Remotely ☐ Hybrid (in-person & remote)**

**If determined you need to be seen in person, would you be comfortable coming into our office?**
**☐ Yes ☐ No**

**Do you have access to a private, quiet space for remote testing? ☐ Yes ☐ No**

**Do you own or have access to a device with internet connection, microphone, and webcam (e.g. smartphone, iPad, tablet, computer)? ☐ Yes ☐ No**

**Are you comfortable with your skills for communicating over the internet?**
**☐ Not at all ☐ Somewhat ☐ Very**

**Can we send you a follow-up survey after testing is completed? ☐ Yes ☐ No**

**If yes, how would you like us to send it to you? ☐ Mail ☐ Email**

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**LANGUAGE ABILITY:**

**Is the client fully fluent in English: ☐ Yes ☐ No**

**Can the client be tested in English: ☐ Yes ☐ No**

**Client Primary Language: ☐ English ☐ Spanish ☐ Other _____**

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**MEDICAL INFORMATION:**

**Known allergies of client: _____**

**Current medications (Name and Dosage): _____**

_____

**Other important medical information: _____**

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**Record #**: _____
**Received**: ___/___/_____

**ALTERNATIVE CONTACT INFORMATION IN-CASE OF EMERGENCY:**

**Person to notify:** _____

**Address:** _____

**Phone Numbers: Home:** _____ **Work:** _____

**Cell:** _____ **Relationship to client:** _____

**SCHOOL INFORMATION (IF APPLICABLE):**

**Name of school/Town:** _____ **Grade:** _____

**School Contact Person Name/Title:** _____

**Phone Number:** _____

**School Address:** _____

**School Phone Number:** _____

**Who suggested that you get an assessment?**

| | |
|---|---|
| ☐ **Self** | ☐ **Therapist:** |
| ☐ **PCP/ Pediatrician:** | ☐ **Psychiatrist:** |
| ☐ **WJC Consortium Site:** | ☐ **DCF:** |
| ☐ **Teacher:** | ☐ **Attorney:** |
| | ☐ **Other:** |

**If you are considering using our report in a legal case, please indicate how you expect to use it:**

_____

**PROVIDERS:**

**Primary Care Physician: Name:** _____

**Agency/Center:** _____ **Phone Number:** _____

**Therapist: Name:** _____

**Agency/Center:** _____ **Phone Number:** _____

**Psychiatrist: Name:** _____

**Agency/Center:** _____ **Phone Number:** _____



**Record #:** _____

**Received:** ___/___/_____

**Other Professionals who work with you: (E.G. Intensive Care Coordinator, Family Partner, InHome Therapist, Therapeutic Mentor, DCF Case Worker)**

**Name: _____ Role: _____**

**Phone Number: _____**

**Name: _____ Role: _____**

**Phone Number: _____**

**What specific questions do you hope assessment will answer? (NEEDS TO BE COMPLETED)**

**Has an assessment ever been done in the past? When? Where? Please send us copies of previous reports if available.**

**Have you previously received psychological testing/assessment services here at the Brenner Center?: □ Yes □ No**

****Please note that our site is best accessed by car and is not easily accessible by public transportation. Our hours of operation are Mondays through Fridays from 9 to 5. ***



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## INSURANCE FORM

CLIENT NAME _____ SS # _____-___-_____DOB ___-___-_____

SUBSCRIBER NAME _____ SS # _____-___-_____DOB ___-___-_____

**INSURANCE PLAN:** Please select your insurance plan and provide the insurance ID number.

☐ MBHP - MMIS # _____

☐ Tufts Health Together - MMIS # _____

TUFTS ID N # _____

☐ BMC Health Net - MMIS # _____

☐ Tufts Health Together - MMIS # _____

☐ Fallon Health/Wellforce Care- MMIS # _____

☐ Steward Health Choice - MMIS # _____

☐ Beacon – BEACON ID # _____

☐ BLUE CROSS BLUE SHIELD - Policy # _____

Insurer _____

Billing Address _____

Telephone # _____-_____-_____

Co-Pay _____Deductible _____

**This is important. Please be sure to tell us if you have a co-pay or deductible, and the corresponding amounts.**

*****PLEASE ATTACH COPY OF INSURANCE CARD*****

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT & ASSIGNMENT AUTHORIZATION

1. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to M. Gorman Psychological Associates (Brenner Center). A photocopy of this signed statement will be considered as effective as the original. Assignment will remain in place until revoked in writing by me.

PATIENT SIGNATURE: _____ DATE: _____



**Record #**: _____

**Received**: ___/___/_____

**INSURANCE AND FINIANCIAL POLICIES AT THE BRENNER CENTER:**

1. **Insurance:** Initial: _____
   Knowing your insurance information is your responsibility. Please contact them with questions about coverage if/when they arise. Specifically, Brenner Center will submit an authorization request to your insurance for coverage. If this is authorized, you will only be responsible for any co-pays and deductibles that are part of your insurance plan. It is ***your responsibility*** to check if you have a mental health care co-pay and deductible **and to inform us**. Any co-pay or deductible payments are due at the time of testing.

2. **Deductibles:** Initial: _____
   By signing this you agree that if you have a deductible, and you have not used it up, you will have to pay us directly the amount needed to use up your deductible (we will provide a receipt), before we can bill your insurance for the rest of our charges. **Please be informed about your deductible, and inform us.**

3. **Proof of insurance:** Initial: _____
   All patients with insurance coverage must complete our intake forms and provide a current, valid, insurance card. This card will be copied and stored with your patient chart. If insurance coverage changes or expires, you must provide us with a current card as soon as it is issued. Please be advised that M. Gorman Psychological Associates (Brenner Center) may not be in network for your new insurance, and we will not be able to move forward with testing if you change to an out of network policy.

4. **If you do not have insurance, payment in full is expected before we begin to provide services. We accept checks and credit cards. Please make checks payable to William James College**

□ I plan to pay an out-of-pocket fee for supplemental academic testing ($1000.00) Initial: _____

□ Rather than going through insurance I plan to pay out-of-pocket for all testing Initial: _____
*(If checked please complete the Specialty Services Financial Agreement on the next page)*

NAME (please print):_____

PATIENT SIGNATURE: _____

DATE: _____



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**SPECIALTY SERVICES FINANCIAL AGREEMENT FOR PRIVATE PAYMENTS:**

If you choose to pay out-of-pocket, the cost will be $3500.00 due at the time of testing.

If your or the client's school has agreed to pay for testing, please reach out to inquire about our school-paid evaluation services.

We ask that you submit payment for your bill in full by the start of your first testing appointment or by the date agreed upon in an alternative payment schedule. **Accounts not paid within the terms are subject to a 1.5% monthly finance charge.**

If you seek reimbursement from your insurance company with which we are OUT OF NETWORK we will provide you with an itemized receipt, so that you can seek reimbursement, but are not otherwise responsible for communicating with your insurance company directly.

You can submit payment by:

- Sending us a **check** made out to *William James College*
- Paying with **credit card** via secured system. Call our billing department at 617-327-6777 x1119 to pay over the phone. You can also pay via credit card at the time of your initial appointment.

I agree to the terms described above and acknowledge responsibility for payment of the bill in full:

_____
PRINT NAME

_____ _____
PATIENT SIGNATURE DATE

If you elect to pay privately for testing and you have an insurance with which we are in-network (MBHP, Beacon private or public, Tufts Health Together, BCBS), **you will not be eligible for reimbursement.**

If you elect to pay privately for testing and do not have insurance that we are in-network with, you may be eligible for reimbursement. You, the client, are responsible for calling your insurance company to verify directly regarding reimbursement rates. The Brenner Center does not guarantee reimbursement, nor does the Brenner Center assist in requesting reimbursement from your insurance company.

Please note that if your insurance changes it is your responsibility to inform the Brenner Center prior to the start of the evaluation in order to avoid paying out of pocket. Choice of payment method may influence the clinician you are assigned to, which may, in turn, influence the wait time for your assessment.

I have read and understood the above policy regarding my eligibility for reimbursement.
Initial: _____



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**Mutual Respect and Responsibility Statement**

The Brenner Center has a longstanding commitment to welcome and serve our whole community in an atmosphere that supports greater inclusion, multiculturalism, racial justice, and equity. We expect staff, partners and clients to work in collaboration to achieve this goal. To that end, we reserve the right to deny or discontinue care to, and refer out, any patient or associate/guardian that treats Brenner Center clinicians and/or staff in a disrespectful or abusive manner, including on the basis of any characteristic protected by law (e.g., race, color, religious creed, national origin, sex, gender identity, sexual orientation, genetic information, pregnancy or a condition related to said pregnancy, handicap, perceived handicap, ancestry or status as a veteran). Similarly, we request that any partner or client notify the Practice Manager, Assistant Director, or Executive Director if you believe that the actions of anyone involved with the Brenner Center (clinicians, employees, etc.) do not meet these basic standards of conduct.



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## Adult Informed Consent

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I understand that I am seeking to participate in a psychological evaluation conducted by the Brenner Assessment Center at the William James College, Graduate Education in Psychology. The Brenner Assessment center is staffed by doctoral psychology students, post-doctoral psychology fellows, license-eligible psychologists, and licensed psychologists under the supervision of the center's Executive Director, Kelly Casey, Ph.D., or the Coordinator of Off-Site Assessment for the APA Consortium, Dr. Shannon Lewis, Psy.D. Dr. Casey is a licensed psychologist and Health Service Provider in the State of Massachusetts nd the State of Rhode Island. Dr. Lewis is a licensed psychologist and Health Service Provider in the State of Massachusetts.

Based upon the presenting diagnostic issues, the Brenner Assessment Center staff may choose to administer a variety of tests tailored to address my needs. These procedures may include intellectual, cognitive, personality, or academic measures, in order to elucidate how I function best. Brenner Assessment Center staff may also need information from other sources such as previous assessments, schools, physicians, and psychotherapists.

The assessment team will share its findings with me. With my permission, they will also share findings with other professionals or any other persons or agencies which I designate. The Brenner Assessment Center will also provide to me, in a timely manner, a written report that will summarize its findings and provide strategies and recommendations that will serve me. Completely anonymized data may be used for quality assurance and research purposes. The supervising psychologists on my case may observe all or part of my assessment.

I have been informed that by agreeing to participate in this evaluation, I will be contributing to the education and training of advanced doctoral students and post-doctoral professionals. I also have been informed that I have the option to refuse to participate in this evaluation or withdraw from it, without prejudice, at any time.

I have read this form and understand fully the terms of my participation in this evaluation. I agree to participate in this assessment as described and freely give my consent.

_____ ____/____/_____

Signature Date

_____ Printed

Name

My data may be used for quality assurance and research purposes provided that all uniquely identifiable health information has been removed from the record prior to analyses. In keeping with Protected Health Information requirements as set forth in the HIPAA Privacy Rule, no information will be made available that can be linked to me. ☐ **Accept** ☐ **Do Not Accept**



**Record #**: _____

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## Notice of Policies and Practices to Protect Your Privacy

The Brenner Assessment Center is committed to providing services in a manner that acknowledges the uniqueness and dignity of our clients. We understand the information you share with us is personal and we are committed to protecting your privacy.

In addition, you have specific rights to privacy and access to information concerning your protected health information under federal and state law. The federal law is known as the Health Insurance Portability and Accountability Act (HIPAA). Protected health information (PHI) refers to any information in your health record that could identify you.

Parents and legal guardians of minor children have the same rights on behalf of their children or those in their care, until those children reach their 18th birthday.

This is an important document. Your access to information, the extent of your privacy, and the release of psychological information are explained. It is our legal and ethical responsibility to you to make sure you receive sufficient information to understand your rights. If you have questions, please ask our staff. Your acknowledgement of this notice is required before services can be provided.

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## Privacy while receiving services and confidentiality of records and communications

Information about you or the services you receive will not be shared outside this center unless you specifically authorize it in writing. You may cancel all such authorizations at any time by submitting a written notice. Exceptions to this are information already shared with your authorization or information needed to obtain payment from your insurer.

Within the center, only the minimal information necessary to provide services is shared and only with those staff who have a need to know. Information may be shared for the purposes of coordinating your assessment or related services and receiving supervision. In addition, information may be shared to obtain reimbursement from your health insurer, to determine eligibility and obtain prior approval, or in the process of an audit.

Certain circumstances allow the use or release of information without your authorization. While it is our policy to obtain permission if possible, we are not required to in order to protect you or others from harm or to comply with federal law. These exceptions to confidentiality include the following instances:

1) In an emergency, we may communicate with emergency or related personnel to ensure your safety or arrange for treatment;
2) When there is reasonable cause to suspect abuse or neglect of minors, elders (age 60 or older), or people with disabilities, we are mandated to submit a report to appropriate authorities;
3) If you communicate an explicit threat to harm yourself or another identified person, we may contact family members or other individuals who can assist in protecting you, arrange for hospitalization, or notify law enforcement; in the event another person may be at risk, we are mandated to take specific precautions which may include warning the potential victim, notifying law enforcement, or arranging for hospitalization;
4) If required by law or judicial procedure overriding privileged information related to court proceedings or evaluations requested by a third-party or the court, we may communicate the requested information;
5) If you are a member of the armed forces, we may be compelled to release information to the military;



**Record #**: _____
**Received**: ___/___/_____

6) For government concerns about national security, the safety of the President or related personnel, we may be compelled to release information.

## Rights concerning consent to treatment and access to information

You also have specific rights related to access to information in your health record, and information about the staff, services, or administrative operations. This includes the following liberties and privileges:

- Receipt of confidential communications at an alternate telephone or address other than your home upon request;
- The name and specialty of any person responsible for your assessment, supervision of staff, or the coordination of your assessment upon request;
- Informed consent, meaning a full explanation of services provided and any potential risks;
- A copy of any rules or regulations that apply to the conduct of staff upon request;
- Information about financial assistance available;
- The ability to refuse services by particular students or staff without jeopardizing services, and the ability to refuse to participate in research or to refuse services when primarily provided for educational or informational purposes;
- An itemized statement of charges submitted to any third party upon request;
- The ability to inspect your medical records or receive a copy for a fee equal to copying expenses, not including information obtained from other agencies; we may provide a summary as an alternative if there is compelling evidence that releasing your record would endanger you or another person;
- An explanation of any relationship the Center or its staff has with other agencies related to services you receive, including an explanation of ownership or financial interest as it relates to services you receive;
- The freedom to request an amendment of your record if you feel it is incorrect or incomplete; we may disagree with good cause and you may request a review of such a decision;
- An accounting of disclosures of your information for purposes other than treatment, payment, health care operations, or those made with your authorization;
- The ability to express complaints without being compromised for making the compliant.

## For more information

If you would like more information about your privacy rights, or are concerned that we have violated your rights, please contact our Privacy Officer at 617-564-9469. Complaints must be made in writing. You may also file written complaints to the Director, Office for Civil Rights of the U.S. Department of Health and Human Services at 800-221-9393. Any person whose rights are violated may file legal or civil action in accordance with law.

This notice is effective as of April 14, 2003. We reserve the right to change this notice and our privacy practices. Revised notices will be posted in our office and made available on request.



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## Acknowledgement of Patient Rights and Privacy Rights and Practices Notice

By signing below, I acknowledge that I have received the Notice of Patient Rights under HIPAA regulations and understand my rights or the rights of my child as a client of the Dr. Leon O. Brenner Center for Psychological Assessment and Consultation. I also understand the procedure should I wish to withdraw myself or my child at any time from the services being provided by the Brenner Assessment Center.

_____ _____

Patient Signature Date

_____

Printed Name



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## Release Information—Adult

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*To be filled out for any individuals you think Brenner Center personnel should communicate with in order to best understand the referral question(s) you have asked us to answer. These individuals might be a school teacher, physician, therapist, etc.*

Name of Client: _____

Date of Birth: ____/____/_____

Social Security #: _____

I understand that the purpose of this release is to assist with my evaluation by improving communication between professional service providers in the Brenner Assessment Center at William James College, Graduate Education in Psychology and important individuals in my life. To further this goal, I authorize:

Name:_____

Phone Number: _____

Address: _____

to release information regarding myself to the Brenner Assessment Center at William James College, Graduate Education in Psychology.

The specific information to be released is: _____

_____

_____.

☐ Admission or intake summary

☐ Discharge or termination summary

☐ Psychiatric/Psychological assessment

☐ Evaluation report

☐ Medical records

☐ Drug and alcohol abuse treatment info.

☐ Lab reports

☐ HIV or AIDS Info.



**Record #**: _____

**Received**: ___/___/_____

☐ School Records: including cumulative record, health record, IEP, and any testing or social history

☐ Verbal exchange of information ☐ Other_____

My record may contain information about drug abuse, alcoholism, and/or alcohol abuse.

Check one: ☐ I am willing; ☐ I am not willing to have this information disclosed to the Brenner Center.

My record may contain information relating to AIDS or my HIV status.

Check one: ☐ I am willing; ☐ I am not willing to have this information disclosed to the Brenner Center.

I also authorize service providers in the Brenner Assessment Center at William James College, Graduate Education in Psychology to communicate with the above mentioned person _____.

This release will remain in effect until the completion of my evaluation at the Brenner Assessment Center.

I understand that:

- I may revoke this release at any time by submitting a written request to my evaluator at the Brenner Center or its Executive Director, Kelly Casey, PhD. This release may be revoked except to the extent that it has already been acted upon or if the release is obtained as a condition of obtaining insurance coverage (other laws provide the person the right to contest a claim under the policy)
- I may refuse to sign this release. If I refuse to sign this release, my treatment, payment, health plan enrollment, or eligibility of benefits will not be affected
- If re-disclosed by the person, information released on this authorization is no longer protected by The Brenner Center
- This release will expire in 1 year or otherwise as indicated upon a specific event or date: _____

**I have carefully read and fully understand the above information, and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed.**

_____ ____/____/_____

Signature of Client or Authorized Person Date

_____ _____

Printed Name Relationship to Client

_____ ____/____/_____

Signature of Client (if another person has signed) Date



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_____ _____

Printed Name Relationship to Client

_____ ____/____/_____

Signature of Client (if another person has signed) Date



**Record #**: _____

**Received**: ___/___/_____