Date:_____

missouri river HEALTH

Forensic Registration Form:

Client's Name:_____ Gender:_____
First M.I. Last

Date of Birth:_____/_____/_____

Address:_____
Street Address City State Zip Code

Social Security Number:_____ Responsible Party:_____
Address:_____

Home Telephone Number:_____ Cell Phone Number:_____
Email:_____

Client's Employer/School:_____

Partner's Name:_____

If Child: Father's Name:_____ Employer:_____
Mother's Name:_____ Employer:_____

Primary Care Physician:_____

Nearest Relative:_____ Relationship:_____

Dr. Shannon Weisz or Dr. Robert Johnson have been asked to conduct a forensic psychological assessment of you in connection with your legal case. They are seeing you for the sole purpose of facilitating a forensic assessment and **not** for therapy. You are therefore not a patient of theirs and the therapist-patient confidentiality and privilege is **not** applicable.

This evaluation is for legal purposes only and is not to guide diagnosis or treatment.

By signing below, I indicated that I understand and agree to the nature and purpose of this assessment.

Client Signature:_____ Date:_____

Consent for Forensic Evaluation

Client Name:_____ Date of Birth:_____

*Please **READ** each item (front and back of page), **Initial** each item and then **Sign** and **Date** the back of this form.*

____1. CONSENT

I agree and consent to a forensic evaluation by Dr. Shannon Weisz or Dr. Robert Johnson, for legal purposes to which I am a party. I understand that the evaluation will consist of a personal interview. I understand and agree to additional repeat "follow up" or "update" sessions with Dr. Weisz or Dr. Johnson, if needed, to complete the evaluation. I understand that they will be part of the same evaluation and will follow all the rules stated below.

_____2. ACKNOWLEDGEMENT OF NON-TREATMENT

I acknowledge and agree that this evaluation is not treatment of any ailment or condition of any kind. I understand that although Dr. Weisz and Dr. Johnson are psychologists, they are not acting as my personal psychologist by conducting this evaluation; I also understand that I am not their patient because of this evaluation. Dr. Weisz or Dr. Johnson will not provide any medical or psychological treatment with this evaluation. Dr. Weisz or Dr. Johnson and I do not have a psychologist-patient relationship. This evaluation is for legal purposes only and is not a guide to clinical diagnosis or treatment.

_____3. COMPLIANCE WITH THE EVALUATION

I understand that I may refuse to complete any part of the evaluation and I acknowledge that my refusal to comply with any part of this evaluation will be documented and may be reflected in the final report.

_____4. WAIVER OF CONFIDENTIALITY

I understand that this evaluation is being conducted for a legal purpose to which I am a party or have an interest. I acknowledge that I have no expectation of privacy as to any communication or information I provide to Dr. Weisz or Dr. Johnson. Further, I agree to waive any right of confidentiality I may have regarding any information I disclose to Dr. Weisz or Dr. Johnson during the evaluation process.

_____5. FINANCIAL RESPONSIBILITY

I understand that charges for this evaluation are my financial responsibility and payment is due prior to services rendered. Amounts due at the time of services are ***ESTIMATES*** and I understand that I will be billed for charges that exceed that estimate.

____6. DISCLOSURE

I am aware that this examination is being done at the request of a third party. I understand and I authorize Dr. Weisz, Dr. Johnson, and Missouri River Health to disclose any information necessary and appropriate to explain and/or discuss the evaluation results to that third party. This includes, but is not limited to Judges, attorneys, probation officers, school officials, police officers, insurance companies, employers, administration, or other individuals associated with my legal case.

_____7. **NON-BIASED WITNESS AND REPORT**

Dr. Weisz or Dr. Johnson have explained to me and I understand that the written report and/or testimony in court may be favorable or unfavorable to my case and that this will be discussed with my attorney and a written report will be prepared.

_____8. **REPORT**

I understand that any report created as a result of this evaluation process for my legal case will not be delivered to me or accessible by me from Dr. Weisz or Dr. Johnson. I understand that the report will be sent directly to the third party that requested the evaluation. I understand and acknowledge that any request for access to the report must be directed to the third party and they may deny my request.

_____9. **HIPAA**

I understand and agree that I am not receiving health care services from Dr. Weisz or Dr. Johnson and that they are not a "covered entity" under the Health Insurance Portability and Accountability Act. I further understand that I will not have access to any records created by Dr. Weisz or Dr. Johnson as a result of this evaluation and will not require any account of disclosures of my information made by Dr. Weisz or Dr. Johnson.

_____10. **INCOMPETENCY HEARING**

If this is an evaluation for incompetency due to criminal charges I understand that pursuant to 50Pa.C.S.7402e(3) I am entitled to have counsel present with me and am not required to answer any questions or to perform tests unless my counsel has moved for or agreed to the evaluation. If this is an evaluation for incompetency due to criminal charges, I understand that nothing said or done by me during this evaluation may be used as evidence against me in any criminal proceedings on any issue other than that of my mental condition.

_____11. **SELF-INCRIMINATION**

I am aware that other than as described in Section 9, any self-incriminating statements made by me during this evaluation may be reflected in the report and result in criminal charges or civil complaints being filed against me. Dr. Weisz and Dr. Johnson have provided me the opportunity to ask questions regarding this consent and have answered all my questions.

_____12. **VALUABLES**

The client is responsible for retention of personal articles. Missouri River Health will not assume responsibility for the loss of client's personal articles (e.g., money, jewelry, eyeglasses, dentures, hearing aids, clothing, etc.).

Signature of Client:_____ Date:_____

Print Name of Client:_____

Signature of Parent or Legal Guardian or Legal Representative:_____

Relationship to Client/Minor:_____ Date:_____

Shannon Weisz, PsyD
Robert Johnson, PhD
Licensed Psychologist(s)
North Dakota State Licensed Psychologist

missouri river HEALTH

Informed Consent for Forensic Psychological Assessment

Drs. Shannon Weisz and/or Robert Johnson have been asked to conduct a forensic psychological assessment of you in connection with your legal case. This form was written to give you information about this assessment process. This release is for the sole purpose of facilitating a forensic assessment and **not** for therapy. You are therefore not a patient of Dr. Weisz or Dr. Johnson and the therapist-patient confidentiality and privilege is **not** applicable. The goal of this assessment is to answer questions about you and the difficulties you may be having. The assessment will contain several parts, which may take more than one session.

Dr. Weisz or Dr. Johnson will interview you and/or your family. They will ask you and/or your family about yourself, your life and circumstances regarding your legal case. If there are any questions that make you uncomfortable, please let them know so that you can talk about your concerns.

Dr. Weisz or Dr. Johnson will be giving you several standardized psychological tests. They will discuss the instructions in detail when they give you the tests and it will be important that you understand them. If at any point, you are unclear as to the instructions, please let Dr. Weisz, Dr. Johnson, or their staff know immediately so that we can ensure that you understand.

Dr. Weisz or Dr. Johnson will be reviewing records and talking with people, such as family members, friends, co-workers, physician, clergy and/or current/former therapist whose names they obtain from you, to get more information about you. This is to help them in finding materials that would provide outside corroboration to what you have to tell them. Upon signing this form, you are providing Dr. Weisz, Dr. Johnson, and Missouri River Health with a release and giving permission to contact people relevant to your case. We will only contact these people with your permission.

It is important that you be as honest as possible when responding to the items on the standardized tests, providing information during the interview, and your response to the assessment. Information that is withheld, incomplete, wrong, or misleading may be far more damaging than if Dr. Weisz or Dr. Johnson are able to find out about it now and put it in the context of the report or testimony. It is important for us to discuss any concerns you have in this area. Although, Dr. Weisz and Dr. Johnson will try to be thorough when they interview you, they may not ask about some areas or information that you believe are important. Is so, please tell them so that it can be discussed.

Please read each item carefully and sign below indicating that you understand:

- I understand that my psychological status is being evaluated in connection with my legal case.
- I understand that this release is for the purpose of facilitating forensic consultation and not for therapy and there is no therapist-patient privilege or confidentiality.
- I understand that this release is not a waiver of any attorney work-product privilege or attorney-client privileges should either of such privileges otherwise be available or in effect.
- I understand that Dr. Weisz or Dr. Johnson will write a formal report about me based on the results of this assessment.
- I understand that Dr. Weisz or Dr. Johnson may testify about me and this assessment in deposition and trial(s) related to my legal case.
- I understand that even if I interrupt or discontinue with the assessment, it is possible (depending on applicable laws, on rulings by the court, and/or decisions by the attorney in this case) that Dr. Weisz or Dr. Johnson may be called upon to submit a report and testify about the assessment, even if the assessment is incomplete.
- I understand that Dr. Weisz or Dr. Johnson uses professional copying and test scoring services and that documents from the file may be made available for such services.
- I understand that Dr. Weisz or Dr. Johnson consults with other professional as part of the evaluation practice for mutual professional consultation. I understand that they engage in research and professional conferences in which anonymous evaluation material that he provides may be utilized for these purposes. I understand that my name and unique identifying characteristics will not be disclosed in any research or professional presentations.
- I understand that as part of conducting this forensic evaluation, Dr. Weisz or Dr. Johnson may consult with and exchange information with anyone that may be relevant to this legal matter.
- I understand that state laws may require Dr. Weisz or Dr. Johnson to disclose otherwise privileged information in situations of suspected child or elder abuse, or suspected potential harm to oneself or to another, in instances where the court shall order the disclosure of privileged information, or information to a subpoena for these records.
- I understand that, unless noted otherwise below, a photocopy of this form and my signature is as valid as the original.
- In consideration of Dr. Weisz and Dr. Johnson's agreement to perform this service, I release them and Missouri River Health and each entity from any liability that might directly or indirectly result from the exchange of any information covered by this agreement.
- I take sole responsibility for the information exchanged may be detrimental and damaging to me or to my legal position.
- I agree that this is a legally binding document and that I fully understand the rights, privacy and privileges that I waive by signing this agreement.
- By signing below, I indicated that I understand and agree to the nature and purpose of this assessment, to the ways in which it may be reported, and to each of the points listed above.

Signature of Client:_____ Date:_____

Print Name of Client:_____

Signature of Parent or Legal Guardian or Legal Representative:_____

Relationship to Client/Minor:_____ Date:_____