



***Thank you for applying to the  
Sewall Diagnostic & Evaluation Clinic!***

Evaluations are conducted in person at Sewall Child Development Center,  
940 Fillmore Street, Denver, CO 80206.

Sewall is in the Congress Park neighborhood,  
next to Congress Park in Central Denver,  
and near the Denver Botanic Gardens.

We follow all CDC guidelines for COVID-19 restrictions  
for childcare centers.

Please return your completed application to **Crystal Smith, Clinic Coordinator**,  
via one of the methods below:

- Scan and email to [DEClinic@sewallchild.org](mailto:DEClinic@sewallchild.org). Emailed applications must be scanned and sent as one PDF. We cannot accept individual photos or JPGs.
- Fax to 303-399-1419
- Contact:  
Crystal Smith  
303-399-1800

## Sewall Diagnostic & Evaluation Clinic Application

### Demographic Information

**Today's Date:** \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age of Child \_\_\_\_\_ Gender \_\_\_\_\_

Caretaker(s) Name(s) \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Caretaker Email \_\_\_\_\_

Who has legal custody of referred child? \_\_\_\_\_

Please list everyone living in the child's current home and indicate relationship to child – biological parents and siblings; foster family's biological, foster, or adopted children:

Name	Age	Relationship	Occupation
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Child's Medicaid ID:** \_\_\_\_\_ **Other funding source:** \_\_\_\_\_

**Who referred you and your child to our Clinic?** \_\_\_\_\_

**Please check any and all reasons your child is being referred:**

- |   |   |
|---|---|
| <input type="checkbox"/> Autism Spectrum Disorder       | <input type="checkbox"/> Anxiety or Depression Disorder |
| <input type="checkbox"/> ADHD                           | <input type="checkbox"/> Global Developmental Delays    |
| <input type="checkbox"/> History of Trauma              | <input type="checkbox"/> Intellectual Disability        |
| <input type="checkbox"/> Other Possible Diagnosis _____ |   |

**What concerns do you have about your child?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Speech-language delays         | <input type="checkbox"/> Fine motor delays  | <input type="checkbox"/> Behavioral          |
| <input type="checkbox"/> Hyperactivity                  | <input type="checkbox"/> Gross motor delays | <input type="checkbox"/> Cognitive           |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Sensory processing | <input type="checkbox"/> Ability to focus    |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Social skills      | <input type="checkbox"/> Reactions to trauma |
| <input type="checkbox"/> Peer relationships/friendships |   |  |

Please provide examples:

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Has your child ever lost skills that he/she mastered previously? And if so, please describe.

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### **Language Information**

Primary language of child: \_\_\_\_\_

How does your child communicate with others? Please check current language level.

- No words
- Gestures or signs only
- Single words: (e.g., “mama”; “pizza”; “mine”; “please”; “more”)
- Phrases: 3 to 4 word linked words (e.g., “There my picture”; “I go home”; “Me all done”).
- Fluent Speech: Speaks in 4-5 words sentences: (e.g., “The dog barked at me”, “I want the big apple”; “My mommy’s gonna pick me up”)
- Conversational Speech: Engages in a back-and-forth conversation about a topic (e.g., video game, cartoons, school, holiday, weekend experience).

Primary language of parent/guardian \_\_\_\_\_

Can the child be tested in English? \_\_\_\_\_

Would a Spanish interpreter for parent or child be helpful? \_\_\_\_\_

### **Medical Information**

#### **Birth History**

Pregnancy length: \_\_\_\_\_ Mother’s age at birth: \_\_\_\_\_

Baby’s birth length: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Vaginal birth or Cesarean section: \_\_\_\_\_

Describe any complications with birth or in the newborn period.

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Did baby go home with the mother? Yes  No

If no, please explain: \_\_\_\_\_

Were the following used during the pregnancy?

Tobacco – quantity \_\_\_\_\_

Alcohol – quantity \_\_\_\_\_

Prescription drugs – please list and explain:  
\_\_\_\_\_

Non-prescription drugs – please list and explain:  
\_\_\_\_\_

**Medical History**

Child's primary care provider (PCP) \_\_\_\_\_

Name of practice or clinic: \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Please list other medical professionals who have been and/or are also involved with your child:

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any medical diagnoses?  Yes  No If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list child's current medications:

\_\_\_\_\_  
\_\_\_\_\_

Child's allergies:

\_\_\_\_\_

Are immunizations up to date? Yes  No

Are there any hearing or vision problems? Yes  No  If yes, please explain:

\_\_\_\_\_

Are there any sleep problems? Yes  No  If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Has the child ever had seizures, head injury, or major accident resulting in hospitalization? Yes  No

If yes, please explain. \_\_\_\_\_

**Mental Health Information**

Is your child under the care of a psychiatrist? Yes  No

If so, for what disorder? \_\_\_\_\_

Medications prescribed \_\_\_\_\_

When did psychiatric care begin? \_\_\_\_\_

How often does s/he see the psychiatrist? \_\_\_\_\_

**Psychiatrist Contact Information**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Does your child work with a mental health therapist? \_\_\_\_\_

When did therapeutic care begin? \_\_\_\_\_

If yes, how often does s/he see his/her therapist? \_\_\_\_\_

**Therapist contact information-**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**Family History**

Check if any of the child's relatives have had any of the following:  
Indicate whether on maternal or paternal side of the family.

- |                          | Relationship to Child          | Maternal | Paternal |
|--------------------------|--------------------------------|----------|----------|
| <input type="checkbox"/> | Drug/Alcohol abuse _____       |          |          |
| <input type="checkbox"/> | Trauma _____                   |          |          |
| <input type="checkbox"/> | Speech-language delays _____   |          |          |
| <input type="checkbox"/> | Hearing loss _____             |          |          |
| <input type="checkbox"/> | Motor concerns _____           |          |          |
| <input type="checkbox"/> | Learning disability _____      |          |          |
| <input type="checkbox"/> | Intellectual disability _____  |          |          |
| <input type="checkbox"/> | Mental illness _____           |          |          |
| <input type="checkbox"/> | Autism Spectrum Disorder _____ |          |          |
| <input type="checkbox"/> | ADHD _____                     |          |          |

**Therapist and Service Provider History**

**Sensorimotor**

Has your child ever received physical, motor, and/or occupational therapy evaluation or treatment?

When and where? \_\_\_\_\_

Therapist's name and contact information:

\_\_\_\_\_

Was this evaluation or treatment provided by the school or a private therapist? \_\_\_\_\_

**Speech and Language**

Has your child ever received speech/language evaluation or therapy? \_\_\_\_\_

When and where? \_\_\_\_\_

Therapist's name and contact information:

\_\_\_\_\_

Was this evaluation or treatment provided by the school or a private therapist? \_\_\_\_\_

**Psychological**

Has your child ever received a:

- Developmental Evaluation (at JFK, Children's Hospital or other agency)
- Psychological evaluation
- Neuropsychological evaluation

Date of evaluation \_\_\_\_\_

Provider's name and contact information:

\_\_\_\_\_

**School Information**

Which school does your child attend? \_\_\_\_\_

School district \_\_\_\_\_ Grade \_\_\_\_\_

Phone number \_\_\_\_\_

Does your child have an Individual Education Plan (IEP)? \_\_\_\_\_

If so, what is the primary disability? \_\_\_\_\_

Does your child have an Individual Family Service Plan (IFSP)? \_\_\_\_\_

**Legal and Human Service Information**

Is your child involved with child protective services? \_\_\_\_\_

Name of human services agency \_\_\_\_\_

Caseworker name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Caseworker email \_\_\_\_\_

**Funding Information**

We gather Race and Ethnicity data in order to apply for funding.  
Please select one for each category:

Child's Race:

- Native American Indian       Black or African-American
- Native Hawaiian/Pacific Islander
- Asian           White           Multiracial

Child's Ethnicity:

- Hispanic/Latino       Non-Hispanic/Latino
- Prefer not to specify

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## AUTHORIZATION TO DISCLOSE CONFIDENTIAL/HEALTH INFORMATION

1.) I authorize the Diagnostic & Evaluation Clinic at Sewall Child Developmental Center to obtain from and/or share health information regarding the individual named below:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_

2.) I authorize health information to be obtained from, and/or released to, the following individual or organization:

**Sewall Child Development Center**

Phone Number: 303-399-1800      Fax Number: 303-399-1419

For the purpose of: Diagnostic Evaluation

3.) The type of medical information to be disclosed is as follows (**check applicable**):

\_\_\_\_\_ any/all birth records

\_\_\_\_\_ any/all medical records

\_\_\_\_\_ any/all therapy records

\_\_\_\_\_ any/all mental health records

\_\_\_\_\_ any/all initial and/or triennial IFSP/IEP records including evaluations

\_\_\_\_\_ other

4.) I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, and past medical history, including birth records.

5.) If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

6.) I understand I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that this authorization will expire either one year from the date of signing, or upon this date that I have specified: \_\_\_\_\_

Parent's Printed Name: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Please fax information to the Clinic Coordinator: 303-399-1419.



**Placement History (if applicable)**

Name of foster parents: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date removed from biological home: \_\_\_\_\_

Estimated duration of current placement: \_\_\_\_\_

Circumstances regarding removal: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

In crisis center or receiving home from \_\_\_\_\_ to \_\_\_\_\_

If foster-to-adopt home, estimated finalized adoption date: \_\_\_\_\_

Please list all other placements prior to current home:

DATES	HOME – please state whether foster or biological relative (e.g., paternal grandparent, maternal aunt, etc.) and location
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Plan for child's permanent placement: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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## **PERMISSION TO TEST**

Sewall Child Development Center  
Diagnostic & Evaluation Clinic

Date: \_\_\_\_\_

I, \_\_\_\_\_, give permission for the Sewall Diagnostic & Evaluation Clinic team to administer standardized testing tools to my child, \_\_\_\_\_, in order to perform a full developmental evaluation, including cognitive, social-emotional, speech-language, and motor skills testing. I understand that this assessment will facilitate a program plan for my child and family. I also understand and agree that a copy of the report based on this evaluation will be sent to my child's primary care provider.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Legal Guardian

Agency: \_\_\_\_\_

## Notice of Privacy Practices

Sewall Child Development Center, Inc.  
940 Fillmore Street Denver, CO 80206

Effective 4/26/2019

**THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Please address any questions about this notice to Heidi Heissenbuttel, President/CEO, at 303-399-1800.

A record of care is maintained for all clients of Sewall Child Development Center. Typically, this record contains information regarding date and time of contact, behavioral/emotional symptoms, a client's reported thoughts and feelings, diagnostic information, information about treatment, and billing-related information. Information about a client's family members may also be contained in the record, as such information pertains to client treatment. This notice applies to all of the medical records of your child's care maintained by Sewall Child Development Center.

### **Sewall's Responsibilities**

Sewall is required by law to maintain the privacy of your child's health information and provide you a description of its privacy practices. Sewall will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. Sewall will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

### **Uses and Disclosures**

The following categories describe examples of the way Sewall may use and disclose medical information:

**For Treatment:** Sewall may use medical/mental health information about your child in the provision of services. When working with minor children who are under 15 years of age, Sewall may disclose medical/mental health information about the child to parents, caseworkers (if applicable), or those for whom consent has been provided to share information. Such sharing of information will be to coordinate care and promote the well-being of the minor child.

Sewall may provide other mental health providers, Department of Human Services representatives, legal representatives, and/or other medical professionals and family members with information that should assist them in their work with your child. Please understand that such releases of information occur only with informed consent and would be in case of medical/mental health emergency, the commission of criminal behavior on the part of the client, or by court order.

**For Payment:** Sewall operates through a fee-for-service arrangement in which it is required that clients reimburse Sewall directly. If services are being billed through Medicaid, an insurance provider, or other third party, Sewall will provide the requested information to the appropriate provider. In cases where Sewall provides information to an insurance carrier due to client request, Sewall may use and disclose medical/mental health information about your child's treatment and services. This may include information about symptoms, diagnostic information, information about the goals of treatment, and the treatment plan.

**For Health Care Operations:** Sewall staff may use information in your child's health record to assess the care and outcomes in the case and others like it. The results will then be used to continually improve the quality of care for all clients we serve. For example, we may combine information about many clients to evaluate the need for new services or treatment. We may disclose information to outside entities for educational purposes. The disclosure of such information will not

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identify any clients. We may combine medical/mental health information we have with that of other treatment providers to allow us to see where we can make improvements. We may remove information that identifies your child from this set of medical information to protect your privacy.

We may also use and disclose medical/mental health information:

- To business associates we have contracted with to perform the agreed-upon service and billing for it
- To assess your satisfaction with our services
- To tell you about possible treatment alternatives
- As part of fundraising efforts
- For population-based activities relating to improving program outcomes or reducing treatment cost
- For conducting training programs or reviewing competence of mental health care for professionals

**Business Associates:** There are some services provided in our organization through contracts with business associates; with, for example, our accrediting body, which serves to support Sewall in maintaining high standards of care. When Sewall works with its accrediting body, we may disclose your child's health information to our business associates so that they can perform the job we've asked them to do. To protect your child's health information, however, we require the business associates to appropriately safeguard your information.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical/mental health information about your child to a parent, county caseworker, guardian ad litem, and/or probation officer who is involved in his/her treatment. In addition, we may disclose medical information about your child to an entity assisting in an emergency situation so that your family can be notified about your child's condition, status, and location. Such disclosure, except in cases of emergency, court order, or where existing laws mandate disclosure, are only done with appropriate consent.

**Research:** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your child's health information has approved said research.

**Organized Health Care Arrangement:** This practice is presenting you this document as a notice. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment, as it may affect treatment at the time.

**Affiliated Covered Entity:** Caregivers at other facilities or practices may have access to protected health information at their locations to assist in reviewing past treatment information, as it may affect treatment at this time. Please contact Sewall's Clinic Coordinator at 303-399-1800 for further information on the specific sites included in this affiliated, covered entity.

**As required by law,** we may also use and disclose health information for the following types of entities, including but not limited to:

- The Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, or disability
- Law-enforcement officials
- State and county departments of human services
- The courts
- Health oversight agencies

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**State-Specific Requirements:** The Colorado Department of Human Services requires access to all records as part of its role in oversight of accredited diagnostic and evaluation clinics.

### **Your Health Information Rights**

Because Sewall compiled your child's record which therefore is the physical property of Sewall, you have the right to:

- **Inspect and Copy:** You have the right to inspect and copy information that may be used to make decisions about your child's care. Usually, this means certain health and billing records but does not include therapy notes or other

notes which we are legally forbidden to disclose. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to health information, you may request that the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Amend:** If you feel that the health/medical information we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Sewall. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of the disclosures we make of medical information about your child.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health/medical information we use or disclose about your child for treatment, payment, or health care operations. You also have the right to request a limit on the health/medical information we disclose about your child to someone who is involved in his/her care, or in the payment for his/her care, such as a family member or friend. For example, you could request that information shared about family members not be shared with those same family members.
- **We are not required to agree to your request:** If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about health/medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may ask that we not leave voice mail or email messages, or that notices of treatment staffing be mailed to an alternative location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Clinic Coordinator and submit your request in writing.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice, and the revised or changed notice will be effective for information we already have about your child as well as any information we receive in the future. The current notice will be posted on Sewall's website ([sewallchild.org](http://sewallchild.org)) and include the effective date. In addition, each time you visit Sewall for treatment or health care services, we will have available a copy of the current notice in effect.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Sewall by contacting Sewall's President/CEO at 303-399-1800. You may also file a complaint with the Colorado Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to Sewall will be made only with your written permission. If you provide us permission to use or disclose medical information about your child, you may revoke that permission, in writing, at any time. If you revoked your permission, we will no longer use or disclose medical information about your child for the reasons covered by the written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to your child.

**Heidi L. Heissenbuttel**  
**President/CEO**  
**Sewall Child Development Center**  
**940 Fillmore Street**

Sewall Child Development Center  
Phone Number 303-399-1800

940 Fillmore Street, Denver, CO 80206  
Fax Number 303-399-1419

**Denver, Colorado 80206**  
**303-399-1800**

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By my signature below, I acknowledge having received a copy of Sewall's "Notice of Privacy Practices." I may ask the Clinic team or Sewall's President/CEO questions about this form. I may also request another copy of this Notice from Sewall's Clinic Coordinator.

Printed Name of Client \_\_\_\_\_

Printed Name of Parent \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Parent \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Legal Guardian (if other than biological or adoptive parent):

\_\_\_\_\_

Agency \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## SEWALL DIAGNOSTIC & EVALUATION CLINIC

### Policies and Procedures: Your Rights as a Client

**The following information describes Dr. Sharon S. Jacksi's clinical practice at Sewall Child Development Center's Diagnostic & Evaluation Clinic and provides a disclosure statement. Please review the following information carefully, and feel free to ask any questions that you may have.**

#### **Sharon S. Jacksi, Ph.D.**

Licensed Clinical Psychologist

Sewall Child Development Center

940 Fillmore Street :: Denver, CO 80206 :: 303.399.1800

[www.Sewall.org](http://www.Sewall.org)

### **SERVICES PROVIDED**

I am a Colorado licensed psychologist (#769). Evaluation and consultation services are provided to children and their families at the Diagnostic & Evaluation Clinic at Sewall Child Development Center.

### **QUALIFICATIONS**

Degrees:

B.A. William Smith College

M.A. Vanderbilt University–Peabody campus

Ph.D. Vanderbilt University–Peabody campus

### **IMPORTANT INFORMATION**

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns, or complaints regarding the practice of mental health may be directed to:

Mental Health Grievance Board  
1560 Broadway, Suite #1350  
Denver, CO 80202  
303.894.7800

Regulatory requirements applicable to mental health professionals in Colorado include:

- **Registered psychotherapist** is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

- **Certified Addiction Counselor I (CAC I)** must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- **Certified Addiction Counselor II (CAC II)** must complete additional required training hours and 2,000 hours of supervised experience.
- **Certified Addiction Counselor III (CAC III)** must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- **Licensed Addiction Counselor** must have a clinical masters degree and meet the CAC III requirements.
- **Licensed Social Worker** must hold a masters degree in social work.
- **Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate** must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- **Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor** must hold a masters degree in their profession and have two years of post-masters supervision.
- A **Licensed Psychologist** must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Your rights include the following:

1. You are entitled to receive information about the methods used during this evaluation process, the goals of this evaluation and information concerning fees. You will receive a copy of the written report that is produced from this evaluation. This report is typically sent 4 to 6 weeks following completion of the evaluation.
2. You may seek a second opinion regarding the outcome of this evaluation or terminate this evaluation at any time. In the case of a court ordered evaluation, second opinions and prematurely terminating an evaluation will likely need to be coordinated with the courts.
3. You should know that in a professional relationship sexual intimacy is never appropriate and should be reported to the Grievance Board.
4. Generally speaking, the information provided by and to the client during the evaluation is legally confidential and cannot be released without the client's consent. There are exceptions to confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during this evaluation, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute.pdf>.

## DIAGNOSTIC & EVALUATION CLINIC

Sewall Child Development Center provides developmental evaluations for children ages infancy through mid-teen years. Children participating in the Clinic are evaluated by a multidisciplinary team of professionals that includes myself as the psychologist. In my role as psychologist, I will evaluate several areas of functioning that may include cognitive, academic achievement, adaptive behavior functioning and social-emotional domains. The evaluation process includes reviewing records of your child, obtaining information from caregivers, and obtaining information from your child. Information obtained from caregivers may include requests for caregivers to complete structured questionnaires, participate in structured interviews, and participate in less formal interviews. The purpose of this information gathering is to learn as much about your child as possible. Similarly, your child may be asked to complete more formal psychological tests, participate in interviews, and/or engage in play/activities with myself or other clinic staff. At times, a child's feedback may be audio-recorded for the purpose of accurate information gathering. Any recording is not shared, and it is erased upon completion of the evaluation. Again, the purpose of these activities is to learn as much about your child in a time-limited manner. The goal of the evaluation is to provide feedback on your child's functioning and to provide relevant recommendations that will support ongoing adaptive functioning. Unless court-ordered, your participation and your child's participation in this process is voluntary. The Clinic team is often available to provide verbal feedback immediately after the evaluation. This feedback will include initial impressions and some recommendations for follow-up. The Clinic team will also provide a written report that summarizes contact with your child, provides feedback on obtained results, and offers recommendations for ongoing follow-up. The completed report on your child may be released to those who have legal



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custody of your child. Besides parents, this may include the county human services agency in which you reside or whoever has custody of your child. If your child has a guardian ad litem, this representative of your child's interests may also obtain a copy of the report due to court orders stating that he/she has access to information about your child. It is the practice of Sewall's Clinic team to release a copy of the completed report about your child to your child's primary care provider (PCP). The purpose of sending a copy of the report to your child's PCP is to support continuity of care. The Authorization to Disclose Confidential Information form, which you signed prior to initiating this evaluation, indicates your approval for releasing the report to your child's PCP. If you do not wish to have the report released to your child's PCP, please share this with a clinic staff member as soon as possible. There may be other instances in which the final report about your child is released to other agencies, including the reporting of a reportable health condition and under court order.

**FEES**

**The cost of a comprehensive evaluation is \$3,500.00. Fees are arranged between clients and Sewall prior to the evaluation taking place. A third party payor, such as an insurance company, may cover the cost of services. If any costs will be assumed by the client and/or his/her parent/guardian, these will be fully explained to you. Please do not hesitate to ask any questions.**

**BILLING INFORMATION**

If you are seeking coverage from an insurance company, Sewall's clinic coordinator will work with you to complete the necessary forms. Information about clients, including diagnostic information or other personal information, will be shared with your insurance company and associated managed care organization for the purposes of reimbursement.

If payment is guaranteed through another entity, such as an insurance carrier, it is understood that information may be shared with the insurance company in order to secure reimbursement. Your signature below indicates that personal information may be released to your insurance carrier.

**CANCELLATIONS**

Appointments are scheduled in advance. Sessions not cancelled within 24 hours of the appointment time may result in Sewall not being able to provide the Clinic evaluation in the future.

I have been informed of the license, degree, and credentials of Sharon S. Jacksi, PhD. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent or Legal Guardian **printed name**

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Client, Parent or Legal Guardian **signature**      Date

\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date