Watson
INSTITUTE

Thank you for your interest in the services provided by The Watson Institute's Psychological Services Department.

Prior to the scheduling of your child's initial appointment, please send the following:

- **Completed Intake packet**
- Legible copy of both front and back of **all** insurance cards for verification of benefits – Please enlarge if possible
- Information can be sent in the following manner:

Email to: Intake@thewatsoninstitute.org
Fax to: (412) 741-9021
Mail to: The Watson Institute
Attn: Psychological Services Department
301 Camp Meeting Road
Sewickley, PA 15143

Medication appointments require a physical from your child's Pediatrician to be sent to office before appointment date. The Pediatrician's office may fax the physical / records to (412) 741-9021. The Physical will need to be dated **within the past 12 months.**

If your child is currently on medication with another provider, please also forward a 6 month print out of medications **obtained from your Pharmacy.**

All documents need to be received in our office before scheduling of a Medication Appointment will be made available.

Should you have any questions regarding this packet, please feel free to contact our office at (412) 741-1800 ext. 2903.

The Watson Institute
Insurance Authorization and Billing Information

This document provides an explanation of the insurance and payment process for services provided through the Psychological Services Department at The Watson Institute.

We participate with **most** Blue Cross, UPMC Health Plan, and Pennsylvania Medical Assistance in most counties.

We will call every insurance company to verify benefits and obtain an authorization on your behalf for both participating and non-participating insurance companies.

Your insurance company may or may not give us authorization for you to receive services from The Watson Institute. If they give us permission for you to receive services, we will bill your insurance company on your behalf. In some instances, they may send payment to you directly and we will then bill you for the services. You will be responsible for forwarding whatever payment you receive from your insurance company and also be responsible for all deductibles, co-insurance, co-pays, or non-covered charges. Most likely, if your child has Medical Assistance, these charges **can** be covered.

Please note that if the primary insurance company denies payment either because of not having out-of-network benefits or not having an authorization in place, Medical Assistance will not cover these services either. Medical Assistance is always the payor of last resort and primary commercial insurance needs to be billed first.

Authorization is not a guarantee of payment. We will process all claims to the insurance company(s); however, ultimately any unpaid balance will be your responsibility.

It is important to present the correct insurance card(s) for **every** insurance that you carry for your child, on every date of service. **If your insurance changes or Medical Assistance is added during the process of the evaluation or treatment of your child, please let The Watson Institute know immediately.**

If you do not present every insurance card(s) for every visit, you may receive a bill for the service.

The Watson Institute
Outpatient and IBHS Services Contract

This document contains important information about business policies and services provided through The Watson Institute. Please read it carefully and ask any questions necessary to understand the document. When you sign this document, it will represent an agreement between you and The Watson Institute.

Consent for Psychological Services and Treatment:
I hereby consent for my child to receive an evaluation, psychological/neuropsychological testing, medication management, Intensive Behavioral Health Services (IBHS), and/or therapeutic services from The Watson Institute.

For psychological/neuropsychological testing, I understand that seeking an assessment does not guarantee that The Watson Institute will be able to conclude that my child has the diagnosis I am seeking testing for or that the testing outcomes will result in accommodations or services I am seeking. The psychological testing process will usually occur in three sessions. The first session, which lasts for approximately one hour, consists of a face-to-face interview with me and my child in order to determine the reason for the evaluation, to obtain history and presenting concerns, and to determine if psychological/ neuropsychological testing is necessary. The second session, which occurs in person and lasts for approximately three hours, consists of a test battery selected by the evaluator and administered to my child in order to answer the referral question. I will also be required to complete questionnaires during this session. Finally, a feedback session is scheduled sometime after the testing session in order to discuss the results of the evaluation and recommendations. The feedback session lasts for up to one hour. Following the completion of the feedback session, the testing report will be finalized and mailed out to me no more than three weeks after the feedback session.

For therapeutic services, including IBHS, outpatient individual and group therapy, and medication management, I understand that the nature and goals of my child's treatment will be agreed upon by me and my child's treatment team, and will be documented in a treatment plan that I will be asked to sign. I am aware that the practice of behavioral and psychological intervention and evaluation is not an exact science and I acknowledge that there are no guarantees as to the outcome of any treatments or evaluations that my child will receive.

I understand that the benefits and risks of any of the services provided can be discussed with my child's clinician.

I understand that in order to authorize mental health treatment for my child, I must have either sole or joint legal custody of my child or I must be the child's legal guardian with supportive documentation. If I am separated or divorced from the other parent of my child, The Watson Institute should be notified immediately. I will be asked to provide a copy of the most recent custody decree that establishes custody rights of me and the other parent or otherwise demonstrate that I have the right to authorize treatment for my child. If the other parent shares medical rights based on the custody agreement, I understand that the other parent will also have to provide consent in order for me to schedule my child an appointment at The Watson Institute.

I also understand that I have a right to withdraw my consent for services at any time.

I understand that it is important that I mention promptly to my child's therapist, psychologist, or psychiatrist any concerns or questions that I may have at any time during the process of treatment.

Confidentiality & Release of Information:
I understand that all communications with a clinician and all records relating to the provisions of psychological services are confidential and may not be disclosed without my written consent or the written consent of my child

(age 14 and over) except in those circumstances required by law, such as in instances of reported child or elder abuse or neglect as well as when patients are at imminent risk of committing suicide or homicide.

Most assessments, such as those that occur at the start of therapeutic services or when psychological/neuropsychological testing occurs, require a significant amount of information from the client. Frequently, The Watson Institute will request that I obtain records and any other relevant documentation and provide those records to the clinician. The Watson Institute may also request that I sign release forms on a yearly basis so that information from other relevant individuals, such as parents, caretakers, school officials, teachers, and physicians or other treatment providers, can be obtained. I understand that The Watson Institute will obtain my authorization, on an annual basis, for the release of any records. I am able to withdraw these releases of information at any time. Those who can access the records without specific approval include The Watson Institute employees and contracted employees in the course of their jobs.

Professional Records:
I understand that, pursuant to HIPAA, The Watson Institute keeps Protected Health Information (PHI) about my child in my child's secure Electronic Health Record. It includes assessments, treatment notes, any past treatment records, releases, consents, and billing records. Except in unusual circumstances that involve danger to me or my child, I may examine and/or receive a copy of my child's Electronic Health Record if I request it in writing. In most circumstances, I will be charged a small copying fee.

Research and Program Management:
I understand that my child's clinical materials, such as information obtained through assessment and testing results, may be used for program management, research, and training purposes. Confidentiality is protected and no identifying information is used for research purposes unless I have signed a separate research consent form stating otherwise.

Authorization to Release to the Insurance Company:
I authorize The Watson Institute to release all or part of my child's mental health and medical record by telephone, by encrypted email, by facsimile transmission, or in writing when required or permitted by law or governmental regulation, or as a condition for payment of charges from insurance carriers, third party reimbursors, utilization review bodies, or welfare funds. This authorization also extends to any organization acting on behalf or in place of the insurance companies. The Watson Institute and its employees who render services to my child are hereby released from any and all liability that may arise from the release of the information.

Assignment of Benefits:
In the event my child is entitled to medical or mental health benefits of any type arising out of any insurance policy or from any person or organization who is or may become liable to my child to provide such benefits, I hereby assign such benefits to The Watson Institute. Such insurance includes, but is not limited to, private commercial insurance and any governmental program such as Medicare or Medicaid. I certify that the information given regarding my child's insurance is accurate and current.

Financial Agreement:
In consideration of services rendered by The Watson Institute, I individually obligate myself and guarantee prompt payment of all charges incurred for services rendered to my child when not covered by insurance carriers or others. Insurance co-payments and self-pay charges are due at the time of the visit. Payment will be made of any balance due and not paid by insurance carriers or third-parties within 30 days of final billing. If such payment is not received by The Watson Institute within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. If The Watson Institute does not receive such payment within 30 days of the date such balance is due, the bill may be turned over to an attorney or a collection agency, at which time I shall be

liable for attorney's fees and/or collection agency's fees and expenses. I understand The Watson Institute has the right to examine credit bureau files for financial information regarding collection of unpaid debts.

I certify that I have read and understand the above information and fully accept all specified terms therein.

Child's Name: _____ Date of Birth: _____
Print

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

_____
Witness Signature Date

The Watson Institute

Authorization for Release of Health Information to Primary Care Physician (PCP)

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize The Watson
(printed parent/guardian name)

Institute to disclose to and receive from the primary care physician, all mental health and medical information as may be necessary to monitor the continuity of care and to inform of any change in health status.

PCP Name:_____

PCP Address:_____

PCP Phone:_____ PCP Fax:_____

This authorization becomes effective _____ and may be revoked by me in writing at
(today's date)
any time, except to the extent of action already taken. Unless earlier revoked, this authorization automatically expires on _____. The Watson Institute has forms to use
(one year from today's date)
if I wish to revoke this Authorization at any time before it expires.

- I understand that the information released relates to the medical, mental health, and/or drug and alcohol treatment provided to me/my child.
- I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have placed my initials here _____.
- I understand that information used or disclosed under this authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protection provided to me by law.
- I understand that I am not required to sign this authorization in order to obtain treatment.
- I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part 2.
- I have read this Authorization, or had it explained to me, and I understand its contents. A photocopy of this Authorization is considered valid.

Watson
INSTITUTE

Client's Signature (if 14 years or older) _____ Date Signed _____

Parent/Guardian Signature _____ Date Signed _____

Witness Signature _____ Date Signed _____

If you are the legal representative of the person listed above, please check off the basis for your authority:

☐ Parent of Minor
☐ Guardianship Order (attach copy)
☐ Power of Attorney (attach copy)
☐ Other: _____

☐ **I do not want the primary care physician to receive information about services provided through The Watson Institute.**

The Watson Institute
Telehealth Consent Form

Patient Name: _____ Date of Birth: _____

I/we consent to participate in telemental health services as part of my psychotherapy session, IBHS session, medication management appointment, or psychological evaluation. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means (ex. video/audio platform or phone) between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions.
7. I understand that my therapist, psychiatrist, or psychologist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
8. I understand that I am advised to choose a private location in my home with minimal interruptions during telehealth sessions.

I have read the information provided above can discuss it with my therapist, psychiatrist, or psychologist. I understand the information contained in this form.

_____ _____

Child's Signature (if age 14 or older) Date

_____ _____

Parent/Legal Guardian Signature Relationship to Child Date

_____

Witness Signature Date

The Watson Institute
Insurance Information

** Please note that Pennsylvania Medical Assistance is always the payor of last resort
**All services at The Watson Institute need to be billed through the child's primary Health Insurance first and then to the Medical Assistance plan (if applicable)

Name of Primary Health Insurance: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____
(as it appears on the insurance card)

Policy Holder Date of Birth: _____

Policy Holder Address: _____
(if different than child's address)

Policy Holder Employer: _____

Name of Secondary Health Insurance: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____
(as it appears on the insurance card)

Policy Holder Date of Birth: _____

Policy Holder Address: _____
(if different than child's address)

Policy Holder Employer: _____

Medical Assistance

Please complete if your child is covered under Pennsylvania Medical Assistance. Medical Assistance is always the payor of last resort.

Name of Child: _____
(as it appears on the insurance card)

County of Residence: _____ State ID Number: _____
(10-digit number)

The Watson Institute
Authorization for Automatic Appointment Reminder Text/Email

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

To help patients remember their mental healthcare appointment, and to reduce the number of missed appointments, patients and their families can be sent an appointment reminder via email or text message to a mobile phone.

If you choose to be reminded via email or text message to your mobile phone, you can stop messages at any time. Contact the administrative assistant to have your email address or mobile phone number excluded from text message reminders.

If you wish to be reminded about your appointment via email and/or text message, please complete the information below:

I authorize The Watson Institute to remind me via email and/or text message of future appointments.
I understand that my email address and/or telephone number will not be used for any other reason.
I understand that I have the option to stop reminders via email and/or text message at any time.

Mobile Number: _____

Email Address: _____

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

_____
Witness Signature Date

The Watson Institute
Psychological Services Cancellation Policy

It is the intention of the Watson Institute to be flexible in meeting client and family needs.

We have established the following cancellation policy that will hopefully be both flexible and reasonable, as we work together to provide services to your child. Our policy is based on the need to avoid unfilled appointments. This policy is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

For Psychological Testing: We request at least a 24-hour notice of all cancellations. Failure to contact us to cancel will result in the cancellation of any remaining appointments. It will be the responsibility of the family to contact us to reschedule the appointments. If the testing series is cancelled/rescheduled 3 times or more, the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

For ALL Other Appointments and Therapy Sessions: We request at least a 24-hour notice of all cancellations. It will be the responsibility of the family to reschedule any missed appointments. In the event of 3 or more consecutive cancellations and/or "no shows," the situation will be reviewed and it will be decided if your child may or may not be scheduled with us for future appointments.

Any patient who arrives later than their scheduled appointment time may be asked to reschedule.

Our main office number is (412) 749-2889. Once we receive notice from you, we will contact the staff members involved. However, because we believe that we are offering a very important service to your child, we sincerely hope that you would not feel the need to cancel, except in case of illness or family emergency. We will also extend the same courtesy to you, in the event that our staff needs to cancel for the same or similar reasons.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you and your child in making the best possible use of this important service.

Child's Name: _____ Date of Birth: _____
Print

_____
Child's Signature (if age 14 or older) Date

_____
Parent/Legal Guardian Signature Relationship to Child Date

Watson INSTITUTE

Education Center
Sewickley
301 Camp Meeting Road
Sewickley, PA 15143
(412) 741-1800

Friendship Academy
255 South Negley Avenue
Pittsburgh, PA 15206
(412) 365-3800

LEAP Preschool
Training and Consultation
WISCA
200 Linden Avenue
Pittsburgh, PA 15215
(412) 781-1708

Education Center South
WISCA
230 Hickory Grade Road
Bridgeville, PA 15017
(412) 914-8800

PLEASE READ THIS LETTER CAREFULLY REGARDING YOUR CHILD'S MEDICATION APPOINTMENT

Unmanaged Medical Assistance (FFS-straight ACCESS) will not pay for Psychiatric services that we will be providing effective 7/1/2006. Therefore we will not be able to submit claims to Unmanaged Medical Assistance (FFS-straight ACCESS) for psychiatry services.
IF YOU HAVE A PRIMARY INSURANCE AND UNMANAGED MEDICAL ASSISTANCE (FFS-straight ACCESS AS A SECONDARY

- We will submit claims to your primary insurance for payment for the visit.
- You will be asked to pay, at the time of the visit any co-pay due from primary insurance
- You will be billed for any portion not paid for by the primary insurance company including co-insurance, deductible and non-covered services, etc.
- Your child cannot be seen on the appointment date if the co-pay is not made before the scheduled time with the doctor.

IF YOUR PRIMARY INSURANCE IS UNMANAGED MEDICAL ASSISTANCE (FFS) –STRAIGHT ACCESS ONLY FOR ANY COUNTY.

- We will no longer submit claims to this insurance company, therefor you will be required to pay for the visit in the amount of $110.00 on the scheduled appointment date.
- Your child cannot be seen if payment is not received in full before the scheduled time with the doctor.

We can accept debit or credit cards (except for American Express) for your payments. Please make checks payable to the Watson Institute.

Signature: _____ Date: _____

Client Name: _____ DOB: _____

Watson INSTITUTE

Exceptional Children Achieving Exceptional Results

CONFIDENTIAL

PATIENT HISTORY AND DEVELOPMENTAL QUESTIONNAIRE

Child's Name:_____ Today's Date: _____

Date of Birth: _____ Age: _____ yrs. _____months Sex: M F

Address: _____

_____

Phone Number: ( ) _____ - _____

E-Mail Address: _____

What is the child's understanding of his/her diagnosis?

_____

_____

Please describe why you wish your child to be seen for an appontment and the problem(s) or symptoms(s) your child is currently having:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date: _____

CHILD/ADOLESCENT'S CURRENT PSYCHIATRIC HISTORY:
Has your child received any psychiatric services or medications? Y N
(if not, please skip to the next section)

Psychiatrist(s) /date(s) started: _____

CURRENT PSYCHIATRIC MEDICATIONS :

Name of med.	Dose	Times of day taken	Who prescribed	When started	lowest/highest dose ever taken

PREVIOUS MEDICATIONS : **This is important – please check your records**

Name of med.	Dose	Times of day taken	Who prescribed	When taken	lowest/highest dose ever taken

Name: _____ Date: _____

PAST PSYCHIATRIC HISTORY:
Previous psychiatrists and dates: _____

_____

_____

Previous inpatient treatment or partial hospitalization (hospitals and dates) :

_____

_____

_____

PREVIOUS DIAGNOSES:_____

DEVELOPMENTAL HISTORY of your child:

Mother's age at child's birth _____

Any illness or complications during the pregnancy: _____

Did any of the following occur during the pregnancy?:

☐ smoking ☐ injury to the mother ☐ medications ☐ illegal drug use
☐ alcohol ☐ emotional stress ☐ other_____

BIRTH: Birth weight_____ Did any of the following occur?
☐ emergency delivery ☐ trouble breathing ☐ incubator use
☐ premature ☐ C -section ☐ induced delivery (pitocin)

INFANCY: Did any of the following occur?
☐ poor responsiveness ☐ excessive crying ☐ feeding problems
☐ difficult baby ☐ poor eye contact ☐ sleeping problems
☐ hard to comfort ☐ seemed not able to hear ☐ other

Name: _____ Date: _____

TODDLER: Did any of the following occur?

☐ Did not start talking at 12-18 months
☐ Did not point to indicate interest in something
☐ Played with toys in unusual ways
☐ Did not walk around 12 months of age
☐ Was not toilet trained by 3.5 yrs old
☐ Never played "pretend"

PRESCHOOL AGE:
Preschool from age ____ to _____

Name of preschool or Early Intervention Program, if attended:

_____

Any problems with adjustment, socialization or behavior? _____

_____

Any adjustment/behavioral problems in any grade? _____

_____

Is your child able to maintain friendships? _____

Problems with any of the following? Starting at what age?

☐ fighting___ ☐ legal problems___ ☐ running away___ ☐ alcohol___ ☐ property destruction ____
☐ stealing___ ☐ suspension___ ☐ expulsion___ ☐ firesetting___ ☐ animal cruelty____
☐ abused___ ☐ traumatized___ ☐ sexual activity___ ☐ lying___ ☐ truancy___
☐ drugs___
☐ frequent complaints from teacher(s) or detentions

Comments: _____

_____

_____

Name: _____ Date: _____

CHILD'S MEDICAL HISTORY: (check all that apply)

___allergy to medication(s) _____

___ started menstrual period date: _____ (if female) LMP _____

☐ asthma ☐ ear infections ☐ seizures/epilepsy ☐ headaches
☐ stomach aches ☐ head injury ☐ chronic pain ☐ diabetes
☐ heart problem ☐ liver problem ☐ kidney problem ☐ chronic diarrhea
☐ problems sleeping ☐ genetic testing ☐ vomiting ☐ loss of consciousness
☐ greater than "normal" weight gain or loss recently ☐ EEG ☐ brain imaging
☐ other special test(s)

☐ other (specify)_____

☐ serious accident(s): _____

☐ hospitalization(s): _____

☐ serious illness(es): _____

☐ evaluation by neurologist (who/when): _____

Comments: _____

_____

_____

_____

Pediatrician _____ Tel. # _____

Date of last physical exam_____

*** IMPORTANT: Please have a copy of your child's most recent physical exam sent to the Watson Institute***
ALSO NOTE: If your child sees a specialist, please have a copy of their most recent evaluation sent to Watson Institute

Name: _____ Date: _____

OTHER CURRENT MEDICATIONS (other than psychiatric medications):

Name of med.	Dose	Times of day taken	Who prescribes	When started

FAMILY MEDICAL AND SOCIAL HISTORY:

Parent(s) occupation(s) _____ _____

Current stressors relevant to the family:

☐ financial ☐ legal ☐ occupational ☐ deaths/losses
☐ housing ☐ safety ☐ recent birth/marriage ☐ abuse
☐ marital conflict ☐ violence ☐ illness/health care ☐ legal custody issues
☐ CYF (CYS) involvement: ___ current ___ in the past
☐ other stressor(s) _____

Are any family members medically ill at present? _____

_____

Any significant family medical history (seizures, heart problems, thyroid problems, genetic problems, etc.)?

_____

_____

Name: _____ Date: _____

FAMILY PSYCHIATRIC HISTORY: Have any members of the child's family had any of the following problems?

Problem	Family member(s)	Problem	Family member(s)
☐ Anxiety	_____	☐ Depression	_____
☐ Suicide	_____	☐ Bipolar/Manic	_____
☐ Schizophrenia	_____	☐ ADHD	_____
☐ Learning problem	_____	☐ Autism Spectrum	_____
☐ Mental retardation	_____	☐ Speech problem	_____
☐ Alcohol abuse	_____	☐ Drug abuse	_____
☐ temper problem	_____	☐ Abusive	_____
☐ Legal problems	_____	☐ jail/prison	_____
☐ Psychiatric hospitalization	_____	☐ Institutionalized	_____
☐ Personality Disorder	_____	☐ Other	_____

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name

Thank you for taking the time to complete this form.

Options for returning these forms:

E-mail to: *intake@thewatsoninstitute.org*

Fax to: *(412) 741-9021*

Mail to: *The Watson Institute*
301 Camp Meeting Road
Sewickley, PA 15143
ATTN: Psychological Services Department

Revised 2/2015

The Watson Institute
Directions to Sewickley Location

Directions to The Watson Institute, 301 Camp Meeting Road, Sewickley, PA 15143

From the North:
Take I-79 south to Emsworth- Sewickley Exit 66; follow signs to Route 65 north (Ohio River Blvd.) to Leetsdale; pass the Quaker Valley Shopping Center on right; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From the South:
Take I-79 north to Emsworth- Sewickley Exit 66; follow signs to Route 65 north (Ohio River Blvd.) to Leetsdale; pass the Quaker Valley Shopping Center on right; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From Beaver and the West:
Route 65 south (Ohio River Blvd.) to Leetsdale; to Quaker Valley Shopping Center on left; turn left into shopping center; follow to back of shopping center to stop sign; turn left onto Beaver Street; pass through first stop sign (at school); before second stop sign, make right turn onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.

From Pittsburgh International Airport:
Take Route 60 north toward Moon Business Area; make left onto University Blvd.; follow down the hill through 4 lights passing car dealerships, Robert Morris University; make left turn onto Sewickley Bridge; turn left off bridge; follow to Leetsdale; pass Quaker Village Shopping Center; turn right onto Ferry Street; at second stop sign, turn right onto Beaver Street; make immediate left onto Camp Meeting Road; at top of hill, turn left at the entrance to The Watson Institute; follow road and take the first right after the stop sign. Keep to the left, go up the hill, and follow the signs for Psychological Services. At the top of the hill, make a right and an immediate left into the parking lot. Enter building at main entrance (under the covered driveway). Press the doorbell to the right of the door, and you will be let in to the main lobby.