STEWART R BEASLEY JR., PH.D.
PSYCHOLOGIST
1366 EAST 15TH STREET
EDMOND, OK 73013

ADULT PATIENT INFORMATION

MY NAME: ____

MY ADDRESS: ____
STREET APARTMENT # CITY STATE ZIP

___PERMANENT

___TEMPORARY UNTIL ______________________________ MY BIRTHDAY ______________________________

HOME TELEPHONE NUMBER:________________________ WORK TELEPHONE NUMBER _________________

MY OCCUPATION: _________________________________ MY EMPLOYER: ___________________________

MY MARITAL STATUS: ___ SINGLE

___ MARRIED – SPOUSE'S NAME________________________

___ DIVORCED SINCE_________________________________

___ WIDOWED SINCE ______________________________

PLEASE LIST ALL OF YOUR BIOLOGICAL, ADOPTED, AND STEP-CHILDREN WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE:

NAME	AGE	PLACE OF RESIDENCE	RELATIONSHIP TO ME

PLEASE LIST THE NAMES OF YOUR BROTHERS AND SISTERS WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE:

NAME	AGE	PLACE OF RESIDENCE	RELATIONSHIP TO ME

WHO IS YOUR FAMILY PHYSICIAN? ____

FIRST NAME LAST NAME CITY STATE

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT? ___NO ___YES IF YES, BRIEFLY DESCRIBE: ______________

____

____

____

ARE YOU CURRENTLY RECEIVING COUNSELING OR PSYCHOTHERAPY? ___ NO ___ YES IF YES, BRIEFLY DESCRIBE:

____

____

PLEASE LIST ALL MENTAL HEALTH PROFESSIONALS YOU HAVE CONSULTED IN THE PAST 5 YEARS:

____

NAME LOCATION DATES

____

____

____

INSURANCE INFORMATION:

Insurance Company: ____

Insured's ID Number: ____

Insured's Name: ____

Insured's Address: ____

Insured's Date of Birth: ____

Insured's Place of Employment: ____

WHO REFERRED YOU TO THIS PRACTICE?_________________________________

MAY WE CONTACT THAT PERSON TO THANK HIM/HER FOR THE REFERRAL? ___YES ___ NO

____

SIGNATURE

____

MY SOCIAL SECURITY NUMBER

____

DATE

REV 06/08

MEDICATION RECORD

NAME_______________________________________ **DATE:**__________________________

MEDICATION	DOSAGE	FREQUENCY	FOR	PRESCRIBED BY

Adult Checklist of Concerns

Name: ____ Date: ____________________

PLEASE MARK ALL OF THE ITEMS BELOW THAT APPLY, AND FEEL FREE TO ADD ANY OTHERS AT THE BOTTOM UNDER "ANY OTHER CONCERNS OR ISSUES." YOU MAY ADD A NOTE OR DETAILS IN THE SPACE NEXT TO THE CONCERNS CHECKED.

__ I have no problem or concern bringing me here

__ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals

__ Aggression, violence

__ Alcohol use

__ Anger, hostility, arguing, irritability

__ Anxiety, nervousness

__ Attention, concentration, distractibility

__ Career concerns, goals, and choices

__ Childhood issues (your own childhood)

__ Children, child management, child care, parenting

__ Codependence

__ Confusion

__ Compulsions

__ Custody of children

__ Decision making, indecision, mixed feelings, putting off decisions

__ Delusions (false ideas)

__ Dependence

__ Depression, low mood, sadness, crying

__ Divorce, separation

__ Drug use—prescription medications, over-the-counter medications, street drugs

__ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")

__ Emptiness

__ Failure

__ Fatigue, tiredness, low energy

__ Fears, phobias

__ Financial or money troubles, debt, impulsive spending, low income

__ Friendships

__ Gambling

__ Grieving, mourning, deaths, losses, divorce

__ Guilt

__ Headaches, other kinds of pains

__ Health, illness, medical concerns, physical problems

__ Inferiority feelings

__ Interpersonal conflicts

__ Impulsiveness, loss of control, outbursts

__ Irresponsibility

__ Judgment problems, risk taking

__ Legal matters, charges, suits

__ Loneliness

__ Marital conflict, distance/coldness, infidelity/affairs, remarriage

__ Memory problems

__ Menstrual problems, PMS, menopause

__ Mood swings

__ Motivation, laziness

__ Nervousness, tension

__ Obsessions, compulsions (thoughts or actions that repeat themselves)

__ Oversensitivity to rejection

__ Panic or anxiety attacks

__Perfectionism

__ Pessimism

__ Procrastination, work inhibitions, laziness

__ Relationship problems

__ School problems (see also "Career concerns . . .")

__ Self-centeredness

__ Self-esteem

__ Self-neglect, poor self-care

__ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")

__ Shyness, oversensitivity to criticism

__ Sleep problems—too much, too little, insomnia, nightmares

__ Smoking and tobacco use

__ Stress, relaxation, stress management, stress disorders, tension

__ Suspiciousness

__ Suicidal thoughts

__ Temper problems, self-control, low frustration tolerance

__ Thought disorganization and confusion

__ Threats, violence

__ Weight and diet issues

__ Withdrawal, isolating

__ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues

__ ____

__ ____

STEWART R BEASLEY JR., PH.D. LLC
PSYCHOLOGIST
1366 EAST FIFTEENTH
EDMOND, OK 73013

FINANCIAL POLICY

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your account is part of your treatment.

PROFESSIONAL FEES

My usual and customary fee for a 45-minute individual psychotherapy session is $135.00. After your initial appointment, your psychotherapy sessions will generally be for 45-minutes. On rare occasions, appointments may be shorter or longer than 45-minutes and your charge for that session will be adjusted accordingly.

YOUR INITIAL APPOINTMENT

My fee for your initial session is $175 and will be scheduled for one hour. This one-time fee is for setting up your account and records as well as taking an extensive personal history and clinical interview

FEES FOR OTHER PROFESSIONAL SERVICES

Fees for group psychotherapy, testing, insurance reports, telephone consultations, and consultations away from my office vary and I will be happy to discuss them with you if you require these professional services.

FEES FOR COURT APPEARANCES

Professional fees for any service related to litigation, defense or other court-related or case-related activities are charged at a higher rate and will be discussed with you upon your request.

BROKEN APPOINTMENTS

It is my policy to charge you in full for any appointment you fail to keep and do not cancel at least 24-hours in advance. For your convenience, our main office telephone number [405.341.4313] is answered around the clock. You may cancel an appointment anytime with the answering service but you must contact our office to re-schedule an appointment. Another appointment cannot be scheduled until payment is received for the broken appointment. For persons having a standing appointment, the standing appointment will be cancelled after two consecutive unkept or missed appointments.

CHANGE IN FEES

Professional fees may be periodically adjusted and you will be notified in advance of any adjustment.

PAYMENT OF PROFESSIONAL FEES

All fees for professional services are due at the time services are received-even those planning to utilize health insurance benefits. For your convenience, I accept cash, checks, money orders, VISA. Discover and MasterCard and American Express. Your cooperation with this policy will greatly assist me in keeping my office operating expenses at a minimum and thus allow me to keep my fees competitive with other psychology practices in the area.

REBILLING FEES

Charges for broken appointments or unpaid balances are subject to a $25 per month re-billing fee if the balance remains unpaid over 30 days.

INSURANCE AND THIRD-PARTY PAYMENTS

Paperwork associated with filing and often re-filing insurance claims for my patients has caused a significant increase in my practice costs. We will assist you by providing you with a billing statement after each psychotherapy session that you can then file with your insurance carrier. Your insurance company will reimburse you for covered services. Please be aware that some - and perhaps all -of the services provided may be non-covered services and not considered reasonable

and necessary under Medicare and/or other medical insurance. Your insurance policy is a contract between you and your insurance carrier and I am not a party to that contract. I will, however assist you in whatever way I can if you run into difficulties with your health care policy carrier. Your account remains your responsibility regardless of whether your insurance company pays for my services or not.

STATEMENT OF UNDERSTANDING

I have read the above information and agree to the terms as set out. I have also received a copy of this document for my own files.

____ ____________________________
Signature Date

This signed copy is part of your health records in this office. If you would like a copy, please inform our front desk staff and they will provide you with one.