

Stewart R Beasley Jr., Ph.D., llc

PSYCHOLOGIST
1366 EAST FIFTEEN STREET
EDMOND, OK 73034

PATIENT INFORMATION FOR ADULTS

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET APARTMENT # CITY STATE ZIP

PERMANENT ADDRESS TEMPORARY ADDRESS UNTIL _____

HOME TELEPHONE # _____ BUSINESS TELEPHONE # _____

CELL TELEPHONE # _____ EMPLOYER: _____

E-MAIL ADDRESS: _____ OCCUPATION: _____

BIRTHDAY: _____ PLACE OF BIRTH: _____

MARITAL STATUS: SINGLE
 MARRIED - SPOUSE'S NAME: _____
 DIVORCED
 WIDOW / WIDOWER - SINCE _____

PLEASE LIST THE NAMES OF YOUR BROTHERS, SISTERS, STEP-SIBLINGS, AND HALF-SIBLINGS WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE: (USE BACK OF PAGE IF MORE SPACE IS NEEDED)

NAME	AGE	PLACE OF RESIDENCE	RELATIONSHIP TO ME

PLEASE LIST THE NAMES OF YOUR BIOLOGICAL, ADOPTED, AND STEP-CHILDREN WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE: (USE BACK OF PAGE IF MORE SPACE IS NEEDED)

NAME	AGE	PLACE OF RESIDENCE	RELATIONSHIP TO ME

Who is your primary care physician? _____

Are you currently receiving any medical treatment: YES NO If yes, briefly describe _____

Are you currently receiving counseling or psychotherapy treatment? YES NO If yes, briefly describe:

Please list all the mental health officials you have consulted in the last five years:

Name	Location	Approximate dates
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WHO REFERRED YOU
TO THIS PRACTICE? _____

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

Signature

Social Security Number

Date

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 because _____
- 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, under eating, 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, __other
- 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, overworking, can't keep a job

Any other concerns or issues:

Please look back over the concerns you have checked off and circle the one that you most want help with.

Stewart R Beasley, Jr., Ph.D., llc

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STATEMENT OF FINANCIAL RESPONSIBILITY

Patient's Name _____ Social Security No. _____
PLEASE PRINT

Home Address _____
STREET CITY STATE ZIP CODE

I, the undersigned, assume financial responsibility for all charges incurred by the above named patient.

I understand that all fees for professional services are due at the time services are received.

I understand that an initial appointment is \$175.00 and that payment is due at the time of the appointment.

I understand that Dr. Beasley will charge full fee for any appointment not cancelled at least twenty-four (24) hours in advance and I agree to be financially responsible for paying for those broken appointments.

I understand that I may rescind this agreement in writing after all current financial obligations have been met.

I understand that no future appointments-including standing appointments-can be made until each appointment is paid in full.

I understand that by signing this Statement of Financial Responsibility, I am not entitled to confidential information about the above named patient that is protected by existing federal and state laws and/or Dr. Beasley's professional ethics.

I agree to pay all costs related to collection of unpaid balances, including attorney fees, collections costs, and interest.

I prefer to meet my financial responsibility by using

____ A Debit/Credit card which will be charged after each appointment.

__ Visa __ MasterCard __ Discover __ American Express

Card Number _____ Expires ____/____/20____

____ A Personal or Business Check for the amount after each appointment.

____ Cash for the full amount after each appointment.

____ Other: Please specify _____

Guarantor's Name _____ Social Security No. _____
PLEASE PRINT

SIGNATURE DATE

Billing Address [if different from above]:

Home Address _____
STREET CITY STATE ZIP CODE

Stewart R Beasley, Jr., Ph.D., llc

PSYCHOLOGIST
1366 EAST FIFTEEN STREET
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FINANCIAL POLICY

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful by establishing and maintaining the highest ethical and professional standards possible. To avoid misunderstanding or confusion, this financial policy is being given to you at the beginning of your treatment. Payment of your account is part of your responsibility in your psychotherapy.

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 our initial clinical interview, taking an extensive personal history, and setting up your account and confidential records.

FEES FOR OTHER PROFESSIONAL SERVICES

Fees for group psychotherapy, testing, completing complex 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 OR FORENSIC SERVICES

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. Future 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 missed appointments. You will not be charged for appointments not cancelled 24 hours in advance due to unforeseeable and legitimate emergencies.

CHANGES 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 if you plan 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 assist me in keeping my office operating expenses at a minimum thus allowing 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 and telephone calls associated with filing and often re-filing insurance claims for my patients caused a significant increase in my practice costs. Therefore, we no longer file insurance claims on your behalf. However, we will assist you in

filing your own insurance claims 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 directly for covered services. 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 filing your claims.

It is possible that some insurance companies and Medicare may determine that services provided in this office are neither covered nor are considered reasonable and necessary. You have a right to appeal this decision and we will assist you in doing so.

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.

SIGNATURE

DATE

Rev42010

Stewart R Beasley, Jr., Ph.D., llc
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Credit/Debit Card Information

Please provide your credit/debit card information below. We will treat this information as confidential and disclosed to no one. We will charge your credit card at the conclusion of each appointment. In the event of a missed appointment, your credit card will be charged. Your acceptance of this policy will ensure that your payments will always be up-to-date and made in a timely manner.

PRINT YOUR NAME AS IT APPEARS ON YOUR CARD

BILLING ADDRESS

BILLING ADDRESS

TYPE OF CARD: Visa MasterCard American Express Discover

Card #: _____ Exp. Date: _____

Signature: _____
(Please Note: Your signature gives me permission to bill your card for services provided)

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Authorization Form
For Uses and Disclosures of Patient Health Information

Name: _____ Date of Birth: _____

I hereby authorize STEWART R BEASLEY JR. PH.D.
To **receive/release** the protected health information indicated below from

Name: _____

Address: _____

Phone: _____ Fax _____

Requested Information:

I authorize the disclosure or receipt of the following types of records created from ONE-YEAR-PREVIOUS TO THIS DATE to PRESENT.

- () Consultations () Treatment Summary
() Diagnostic Assessments () Other _____
() Psychological Evaluations

Purpose of the Requested Use or Disclosure: The Purpose of the use or disclosure is at the request of the patient.

Expiration Date: The authorization will automatically expire one year from the date of signature below.

Patient- Please note the following:

You may refuse to sign this authorization. Your refusal will not affect your ability to retain treatment or payment.

1. If the person or parties who are authorized to receive/release the information above are not health care providers or health plan covered by federal health privacy laws. They may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our clinic addressed to: STEWART R BEASLEY JR., PH.D., 1366 East 15th Street, Edmond, OK 73013.
3. The information authorized for release may include reports which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS) and/or mental health information.

Signature _____ Date: _____
Patient or Legal Representative

Capacity of * Legal Representative (If applicable): _____