

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

PSYCHOLOGIST  
1366 EAST FIFTEEN STREET  
EDMOND, OK 73034

**PATIENT INFORMATION FOR MINORS**

CHILD'S NAME: \_\_\_\_\_

CHILD'S ADDRESS: \_\_\_\_\_  
STREET APARTMENT # CITY STATE ZIP

CHILD'S BIRTHDAY: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

School: \_\_\_\_\_  
Grade School Name School District

Father's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Parents Marital Status:  Single  Married  Separated  Divorced

Father's Address: \_\_\_\_\_  
Street Apt.# City State Zip

Mother's Address: \_\_\_\_\_  
Street Apt# City State Zip

Mother's Home Telephone Number: \_\_\_\_\_ Father's Home Telephone Number: \_\_\_\_\_

Mother's Work Telephone Number: \_\_\_\_\_ Father's Work Telephone Number: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Father's Employer: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

PLEASE LIST THE NAMES OF THIS CHILD'S BROTHERS, SISTERS, STEP SIBLINGS, HALF SIBLINGS WHETHER LIVING OR DEAD, THE APPROXIMATE AGE OF EACH, AND WHERE THEY RESIDE:

NAME	AGE	PLACE OF RESIDENCE	RELATIONSHIP TO ME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is this child's physician? \_\_\_\_\_  
First Name Last Name Address

Is this child currently receiving medical treatment?  YES  NO If yes, briefly describe\_\_\_\_\_

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Is this child currently receiving counseling or psychotherapy treatment?  YES  NO

If yes, briefly describe:

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Please list all the mental health officials the child has 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

\_\_\_\_\_  
Custodial Parent's Signature

\_\_\_\_\_  
Custodial Parent's Social Security Number

\_\_\_\_\_  
Date

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CONSENT FOR PSYCHOLOGICAL SERVICES TO A MINOR

I, \_\_\_\_\_, GIVE PERMISSION TO STEWART R. BEASLEY, JR., PH.D. TO PROVIDE  
PLEASE PRINT YOUR NAME

PSYCHOLOGICAL SERVICES TO \_\_\_\_\_ WHOSE BIRTHDAY IS \_\_\_\_\_  
NAME OF CHILD MONTH DAY YEAR

THESE SERVICES MAY INCLUDE BUT ARE NOT LIMITED TO

- CLINICAL INTERVIEW
- PSYCHOLOGICAL EVALUATION
- COUNSELING AND/OR PSYCHOTHERAPY
- OTHER PSYCHOLOGICAL SERVICES AS NEEDED

My relationship to his child is:

Custodial Parent     Non-custodial Parent     Step-parent     Grandparent     Legal guardian

PLEASE ATTACH A COPY OF THE COURT ORDER THAT NAMES YOU THE LEGAL CUSTODIAN OF THIS CHILD. PLEASE NOTE THAT PSYCHOLOGICAL SERVICES CANNOT BE PROVIDED TO THE ABOVE NAMED CHILD UNTIL A COPY OF THE COURT ORDER WHICH NAMES YOU THE LEGAL CUSTODIAN IS PROVIDED TO DR. BEASLEY.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CO-CUSTODIAL PARENT [OPTIONAL]

\_\_\_\_\_  
DATE



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**Adolescent Problems Checklist**

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

Age: \_\_\_\_\_ Person completing this form: \_\_\_\_\_

**Please mark all of the items that apply to your adolescent Feel free to add any others at the end under "Any other problems."**

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's new marriage / new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around," has only younger playmates
- Imaginary playmates, fantasy

- Independent
- Impulsive behaviors such as Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales, etc.
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors—biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics—involuntary rapid movements, noises, or word productions

- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, overworking, can't keep a job

Any other problems:

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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

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## FINANCIAL POLICY

**T**hank 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

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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 \_\_\_\_\_

**Request 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 15<sup>th</sup> 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): \_\_\_\_\_