Tulsa Family Development Center
4520 S Harvard Ave, Suite 200C
Tulsa, OK 74135
Phone: 918-743-3224
Fax: 918-743-9623
Email: tulsafamilycontact@gmail.com

To help us get to know you, come of the issues you are dealing with and to provide you with the proper treatment, it is very important that we obtain detailed information regarding your current symptoms, mental health, medical and background history. Please answer ALL of the questions on the next few pages.

ADULT INTAKE FORM

NAME: ______________________________ DATE: ________________

DATE OF BIRTH _______________________ AGE: ________________

MARITAL STATUS _____________________

GENDER ___________________________

ADDRESS _________________________ CITY __________ STATE ____ ZIP ______

PHONE _______________________ EMAIL ____________________________

WHO REFERRED YOU TO US TODAY? _____________________________________

INSURANCE ____

POLCYHOLDER __________________________ DATE OF BIRTH ______________

PRIMARY CARE DOCTOR ____

REASON FOR TODAY'S VISIT ____

____

____

TOWN AND STATE YOU WERE BORN IN ________________________________

TOWN AND STATE WHERE YOU WERE RAISED __________________________

WHO RAISED YOU? ____

DID YOUR PARENTS DIVORCE WHILE YOU WERE GROWING UP? ____________________
IF YES, how old were you when this occurred?____________________________________

DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS: ____________________________

____

DESCRIBE YOUR RELATIONSHIP WITH YOUR SIBLINGS: ____________________________

____

OF BROTHERS ____ # OF SISTERS ____ I WAS # ____ IN THE BIRTH ORDER

DESCRIBE YOUR CHILDHOOD UPBRINGING/FAMILY EXPERIENCES IN A FEW WORDS:

____

HAVE YOU SUFFERED ANY FORM OF THE FOLLOWING ABUSE:

EMOTIONAL: FROM AGE ____ TO ____
PHYSICAL: FROM AGE ____ TO ____
SEXUAL: FROM AGE ____ TO ____

DID YOU GRADUATE FROM HIGH SCHOOL? _____
DID YOU ATTEND COLLEGE? _____
ARE YOU CURRENTLY WORKING? WHERE? ______________________________________

Job duties and length of employment ____

MARTIAL HISTORY - # OF MARRIAGES: ______

1) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS
2) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS
3) AT AGE ____ # OF CHILDREN ____ LASTING _____ YEARS

STATUS: Current marriage Divorced Widowed

DESCRIBE CURRENT PEER RELATIONSHIPS

DIFFICULTIES FORMING NEW FRIENDSHIPS/MEETING NEW PEOPLE?

HOW WOULD OTHER PEOPLE DESCRIBE YOU? ________________________________

____

HOBBIES/WAYS YOU RELAX AND/OR FIND ENJOYMENT? ________________________

____

SUBSTANCE USE/ABUSE HISTORY

DO YOU CURRENTLY DRINK ALCOHOL? ______
If YES – How much per week and type of alcohol? ______________________________

DO YOU CURRENTLY SMOKE CIGARETTES/VAPE? ______
If YES – How many cigarettes/packs per day? ______

DO YOU CURRENTLY USE ANY ILLICIT DRUGS? ______
If YES – List type of drug(s) ____________________

HAVE YOU EVER BEEN IN TROUBLE WITH THE LAW? _____

DO YOU HAVE ANY CURRENT PENDING LEGAL/CUSTODIAL CONFLICTS? _____

MENTAL HEALTH HISTORY

HAVE YOU EVER HAD OUTPATIENT TREATMENT BY A PSYCHIATRIST? ______
If YES – List the name of provider, length of treatment and problems addressed

____

HAVE YOU EVER HAD OUTPATIENT PSYCHOTHERAPY OR COUNSELING? ______
If YES – List the name of provider, length of treatment and problems addressed

____

HAVE YOU EVER COMPLETED A PSYCHOLOGICAL EVALUATION/TESTING? ______
If YES – List the name of provider, diagnosis, and date of service

____

HAVE YOU EVER BEEN HOSPITALZED FOR PSYCHIATRIC REASONS? ______
If YES – List name of facility, year admitted, length of stay and problems addressed

____

ANY HISTORY OF MENTAL HEALTH ISSUES AND/OR SUBSTANCE ABUSE IN FAMILY?
MOTHER YES NO ____
FATHER YES NO ____
SIBLINGS YES NO ____

ARE YOU CURRENTLY TAKING, OR HAVE YOU TAKEN, ANY MEDICATIONS FOR PSYCHOLOGICAL REASONS? ______
If Yes – Please list medications, time(s) per day, dosage and length of usage.

____

____

MEDICAL HISTORY

DO YOU HAVE ANY CHRONIC HEALTH CONDITIONS? _____
If YES – Please list (e.g., high blood pressure, diabetes etc.)

____

____

DO YOU HAVE ANY PROBLEMS WITH CHRONIC PAIN? _____
If YES – Rate your average pain level (1= Mild, 10=Severe)

1 2 3 4 5 6 7 8 9 10

ANY OTHER MEDICAL PROBLEMS OF INTEREST FOR YOUR MENTAL HEALTH TREATMENT?

CURRENT PROBLEMS:	NEVER	OCCS	OFTEN	VERY OFTEN
Physical appearance	_____	_____	_____	_____
Health problems	_____	_____	_____	_____
Physical pain or discomfort	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Racing heartbeat	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Dizziness, lightheaded, fainting	_____	_____	_____	_____
Confusion or disorientation	_____	_____	_____	_____
Anxious or nervous	_____	_____	_____	_____
Restless or on edge	_____	_____	_____	_____
Poor attention/concentration	_____	_____	_____	_____
Racing thoughts	_____	_____	_____	_____
Spending too much time organizing or planning tasks	_____	_____	_____	_____
Difficulty making decisions or completing tasks	_____	_____	_____	_____
Trouble getting a thought out of your head	_____	_____	_____	_____
Behavior you have to repeat for no reason	_____	_____	_____	_____
Trouble throwing things away	_____	_____	_____	_____
Mood swings, rapid changes in your feelings	_____	_____	_____	_____
Depression, sadness or feeling "down"	_____	_____	_____	_____
Memory problems	_____	_____	_____	_____
Easily fatigued	_____	_____	_____	_____
Increased or decreased appetite	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Loss of interest in pleasurable activities	_____	_____	_____	_____
Flat or reduced emotions	_____	_____	_____	_____
Negative thoughts	_____	_____	_____	_____
Unresponsive to praise or criticism	_____	_____	_____	_____
Loneliness	_____	_____	_____	_____
Feeling of hopelessness	_____	_____	_____	_____
Feeling inferior	_____	_____	_____	_____
Being easily influenced by others	_____	_____	_____	_____

Trouble being alone	____	____	____	____
Feeling distance or detached from others	____	____	____	____
Feeling different from others	____	____	____	____
Difficulty trusting others	____	____	____	____
Trouble having close friends	____	____	____	____
Feeling like no one likes you	____	____	____	____
Thoughts of harming yourself	____	____	____	____
Trouble controlling your temper or anger	____	____	____	____
Conflict with authority figures	____	____	____	____
Lying or stealing	____	____	____	____
Fire setting or other property destruction				

CURRENT PROBLEMS	NEVER	OCCS	OFTEN	VERY OFTEN
Unwanted impulses, urges or desires	____	____	____	____
Intrusive or unwanted thoughts or images	____	____	____	____
Thinking others want to harm you	____	____	____	____
Thoughts of harming someone else	____	____	____	____
Hearing voices that others do not hear	____	____	____	____
Seeing things that other people do not see	____	____	____	____
Repeated images of experiences of traumatic event(s)	____	____	____	____
Feeling out of touch or separate from your body	____	____	____	____
Confusion about who you are	____	____	____	____
Feeling that you have more than one personality	____	____	____	____
Eating, food, exercise or weight concerns	____	____	____	____
Drug or alcohol problems	____	____	____	____
Gambling	____	____	____	____
Work, job, school or career problems	____	____	____	____
Financial problems	____	____	____	____
Legal problems	____	____	____	____
Marriage, family or relationship problems	____	____	____	____
Sex related problems	____	____	____	____
Religious or spiritual problems	____	____	____	____

HOW LONG (days, weeks, months etc.) HAVE THE MAJORITY OF THESE PROBLEMS OCCURRED?

____

TULSA FAMILY DEVELOPMENT CENTER

CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION AND CONFIDENTIALITY AGREEMENT

This form is an agreement between you and Tulsa Family Development Center. When we use the word "you" below, it will mean you as the client or you as the parent guardian, or personal representative of a child.

When we examine, diagnose, treat, or refer you to another health professional, we will be collecting what the law calls your Protected Health Information (PHI). We need to use this information in our office to decide what treatments is best for you. We may also share this information with others who provide treatment to you or need to arrange payment for your treatment or other business or government functions. **Release of psychological information will specifically require your signed authorization.**

By signing this form, you are agreeing to let us use your information in this office and send it to others, **with your permission.** Our Notice of Privacy Practices explain your rights in more details and how we use and share your information.

As a client seeing a psychologist, one of your most important rights involves confidentially. Within certain limits, information revealed by you and/or your child during counseling or testing will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. These limits to confidentiality are as follows:

1. If a client threatens a grave bodily harm or death to another person, a psychologist may be required to inform appropriate legal authorities and the intended victim.
2. If a client expresses a serious intent to grievously harm her/himself, it may be necessary for a psychologist to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect the client from harm.
3. If a client is being evaluated or treated in response to a court order, the results of the evaluation or treatment ordered must be revealed to the court.
4. If a court of law issues a court order signed by a judge, the psychologist is required to provide information specifically requested in the court order.
5. If a psychologist has a good reason to suspect that a child is a victim of physical abuse, sexual abuse, or neglect, he/she is required to report the abuse or neglect to the appropriate authority.
6. If insurance companies involved in third party payment request reports including diagnosis, recommendations, and/or chart notes, this information must be provided.

Please be assured that the professionals at TFDC take your confidentiality very seriously and will make every effort to safeguard it.

I understand the limits of confidentiality as outlined above and hereby give my consent for treatment or evaluation services. Also, by signing this form, you are agreeing to let us use your information in this office and send it to others, with your permission and you are acknowledging that you have received or been offered the Notice of Privacy Practices. Our Notice of Privacy Practices explains your rights in more detail and how we use and share your information.

__________________ ____

DATE SIGNATURE of CLIENT or PERSONAL RESPRESENTATIVE

Tulsa Family Development Center

Financial Policy

We intend to provide you with the best quality treatment and business processed for your care. The following information will help you and our office work cooperatively to achieve this goal.

Our Responsibility

Insurance Verification & Estimating the Cost of Services
As a free courtesy to you, we will verify your insurance coverage. We will estimate as closely as possible your coverage but, until we actually receive a payment from your insurance company, it is only an estimate.

Filing Claims with your Insurance Company
We will file claims with your insurance company. We will provide documentation to your insurance company for claims processing. If they require additional information, we will provide them whatever is necessary to process the claim to maximize your insurance benefits.

Your Responsibility

If Your Insurance Does Not Cover Services
If your insurance does not pay for services or if we are out of network with your insurance, you are responsible for the full payment at the time services are provided. Unless prior arrangements have been made.

Co-Payments, Co-Insurance and Deductibles
Co-pays or co-insurance is due at the time of service. **If your child attends an appointment alone or if someone else provides your child transportation to an appointment, the payment is due at that time.** For your convenience we ask that you put a credit card on file to pay for copays and co-insurance.

Change in Insurance Coverage

If you change insurance during the course of your treatment, it is your responsibility to notify us before your next scheduled appointment so that your coverage can be verified.

Late Cancellations and No Shows for Appointments
We understand that things occasionally arise at the last minute and our professionals make every effort to consider this. However, **it is the policy of this office to charge $125 for missed appointments or late cancellations.** Please call to cancel **24 hours** prior to your appointment.

Account Balances
We will assist you in working with your insurance company for payment of claims but the ultimate responsibility for payment remains with you. After 60 days, any remaining balance not covered by insurance will be due in full.

Forms, Letters and Reports
Requests for letters and completion of forms are rapidly increasing and have thus become very time consuming and costly. Charges for detailed letters and forms will be at the professional's hourly rate based upon the time involved in preparation.

My signature below indicated that I have read and understand the Financial Policy for TFDC and I authorize the release of any medical information to process insurance claims and I authorize payment of medical benefits to Tulsa Family Development Center.

Signature of Client or Personal Representative

Date

PLEASE

FILL OUT THE FORM BELOW

FOR CONTACTLESS PAYMENT

CONTACTLESS PAYMENT CONSENT

Patient Name____

Parent/Guardian (If Applicable) ______________________________

Credit Card #____

Expiration Date______________________ Security Code___________________

Authorized Signature_________________________ Date________________

Tulsa Family Development Center

Policies and Procedures for Testing

This document explains the policies and procedures for testing/evaluation with Dr. Parker Shaw, PhD. PLEASE READ THIS DOCUMENT CAREFULLY AS IT CONTAINS INFORMATION THAT IS IMPORTANT FOR YOU TO KNOW.

Evaluation Process

The evaluation process consists of three stages:

1. Diagnostic Interview: This will be a 45-60 session designed to discuss the reason for the evaluation and relevant information about the child or adult being evaluated. The evaluation process and the cost and payment will be discussed as well.
2. Evaluation: This session is usually 3 to 4 hours.
3. Report Writing: 3-4 hours. You do not have to be here for this appointment.
4. Feedback Session: This will be scheduled after the evaluation report is completed to discuss the results, diagnosis and recommendations. You will receive a copy of the written report at this time. This is appointment for parents only, unless client is an adult.

Financial Policy

Fees:

*** Diagnostic Interview to begin the evaluation - $210.00
*** Assessment, scoring, report writing are charged at $155.00 per unit of services (usually requires 9 units)
*** Feedback - $190.00
*** Other services such as phone calls, letters, reviewing medical records are charged at at the rate of $150.00 per hour.

Payment is due when services are provided unless prior arrangements are made. This includes copay, deductible and /or co insurance. We will file your claims with the insurance company in a timely manner. Checking your insurance policy and coverage is *YOUR* responsibility. **If, for any reason, your insurance does not cover the provided services, you will be responsible for these charges**. Also, if we do not receive reimbursement from your insurance within 90 days, you may be asked to pay the balance. If you have questions about billing, you may call Atlas Billing at 918-299-8232.

If you are not using insurance to pay for the evaluation the total charge will be **$1700.00**. Half will be due at the time of testing and the other half will be due in 60 day.

Scheduling Appointments

The diagnostic interview will be scheduled at the first available time that is convenient for you. The testing time will be scheduled on the doctor's designated testing days at 8:30 am. The feedback session will be scheduled approximately up to 3 weeks after the testing is completed.

IMPORTANT: A mandatory $500 deposit must be paid in order to schedule your diagnostic interview and testing. Please provide a credit card to place on file or mail in a check for your deposit. This will be applied to your overall balance after filing with insurance.

If you do not show up for the appointment, you will be charged a $250 no-show charge. No-shows will lead to referral from our office and not being rescheduled. Your time is valuable, as is ours. If you are unable to keep a scheduled appointment, please call the office 24 hours in advance in order to avoid a late cancellation fee. If you must cancel your appointment for the evaluation, please do as early as possible in order that we may offer this half-day appointment to another client. If you must cancel after office hours, please leave a voicemail. The late cancellation charge for an evaluation appointment will be $250.00. Any late cancel charge will need to be paid at the time of the next appointment or before any additional appointments are made.

The primary benefits of evaluation include obtaining extensive information to better understand the client's strengths and challenges; diagnostic clarification; individualized recommendation which can be implemented at home/school; and a comprehensive written report that can be provided to schools and other professionals to facilitate a better understanding of the client's needs. It is possible that the evaluation may not answer all of your questions or may result in a diagnosis other than what the parent/client expected. Ultimately, it is your decision whether to follow the recommendations generated from the evaluation.

Additional Information for Child Testing

You may either drop you child off at 8:25am and return when the evaluation is complete or you can wait in our waiting room during the evaluation. It is preferred that a guardian be present during testing if the individual is under 15 years of age. We prefer a parent/guardian to remain at our office until testing is completed. If you leave, make sure a working phone number is left with the front desk in case we need to call you.

If your child is ill on the morning of the assessment, please call to reschedule. Attempting to evaluate a child who is not feeling well may yield unreliable results.

Informed Consent for Testing/Evaluation

My signature below indicates that I have read and understood the information contained in this document. I have had the opportunity to ask for clarification of any information that I do not understand. I hereby give my contest to TFDC to conduct a psychological evaluation with myself and/or child.

____

Patient Name Date of Birth

____

Signature of Guardian Relationship Date

____

Signature of Patient Date