Tulsa Family Development Center
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Tulsa, OK 74135
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To help us get to know you, some 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.

CHILD INTAKE FORM

NAME OF INDIVIDUAL FILLING OUT FORM: ______________________
RELATIONSHIP TO CHILD ______________________

NAME: ______________________ DATE: ______________

DATE OF BIRTH ______________________ AGE: ______________

PARENTS ____

PHONE ______________________ EMAIL ______________________

MAILING ADDRESS ______________TOWN______________ZIP______________

INSURANCE ____

POLICYHOLDER ______________________ DATE OF BIRTH ______________

WHO REFERRED YOU TO US TODAY? ______________________________

PRIMARY CARE DOCTOR ______________________________________

SCHOOL ATTENDS: ______________________ GRADE ______________

REASON FOR TODAY'S VISIT ______________________________________

____

SCHOOL HISTORY

IS THE CHILD EXPERIENCING ANY PROBLEMS LEARNING OR TAKING SPECIAL CLASSES?
If Yes, please explain: ______________________________________

IS THE CHILD EXPERIENCING ANY BEHAVORIAL/SOCIAL PROBLEMS AT SCHOOL?
If Yes, please explain: ______________________________________

PLEASE LIST ANY OTHER PROBLEMS/DIFFICULTIES REGARDING SCHOOL:
____

IS THE CHILD CURRENTLY WORKING?
If so. list employer, job duties and length of employment ______
DESCRIBE THE CHILD IN A FEW SENTENCES? ______

______

HOW WOULD OTHER PARENTS/TEACHERS DESCRIBE THE CHILD: ______

______

ANY PROBLEMS RELATED TO SUBSTANCE EXPERIMENTATION/ABUSE? ______

______

MENTAL HEALTH HISTORY

HAS THE CHILD EVER HAD OUTPATIENT TREATMENT BY A PSYCHIATRIST?
If yes, list name of provider and/or office, length of treatment, and problems addressed:

______

______

HAS THE CHILD EVER HAD OUTPATIENT PSYCHOTHERAPY OR COUNSELING?
If yes, list name of provider, length of treatment and problems addressed: ______

______

HAS THE CHILD EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?
If yes, list name of facility, year admitted, length of stay and problems addressed ______

______

ANY HISTORY OF MENTAL ISSUES AND/OR SUBSTANCE ABUSE IN FAMILY?

MOTHER YES NO ______
FATHER YES NO ______
SIBLINGS YES NO ______
OTHER YES NO ______

IS THE CHILD CURRENTLY TAKING, OR TAKEN, ANY MEDICATIONS FOR PSYCHOLOGICAL REASONS? If Yes, please list medications taken, time(s) per day, dosage and length of usage

______

______

MEDICAL HISTORY

DOES THE CHILD HAVE CHRONIC HEALTH CONDITIONS?
If Yes, please list: ______

______

DOES THE CHILD HAVE ANY ALLERGIES?
If Yes, please list: ______

______

LIST ANY OTHER MEDICAL PROBLEMS OR IMPORTANCE FOR THE CHILD'S MENTAL HEALTH TREATMENT?

______

______

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______________