

Tulsa Family Development Center

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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 BEHAVIORAL/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 confidentiality. 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 REPRESENTATIVE

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 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 your 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 consent 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