Tulsa Family Development Center

Child Intake

Chart # _____

NAME OF INDIVIDUAL FILLING OUT FORM: _____

RELATIONSHIP TO CHILD: _____

Name : _____ Date: _____

Date of Birth _____ Age: _____

Parents : _____

Phone #: _____ Email: _____

Mailing address: _____

Insurance: _____

Who referred you to us? _____

Primary Care Doctor:_____

School Attends and Grade : _____

Is the child experiencing any learning or behavioral problems at school?
If yes, please explain: _____

_____

Is the child currently working? _____Where? _____

Please describe the child in a few sentences: _____

_____

How would other parents/teacher 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 the name of the provider, length of treatment and problems addressed

_____

Has the child ever had outpatient psychotherapy or counseling?

If yes, please list name of provider, length of treatment and problems addressed

_____

_____

Has the child ever been hospitalized for psychiatric reasons? Please explain

_____

Any history of Mental Health or Substance Abuse in the Family?

Mother YES NO _____

Father YES NO _____

Siblings YES NO _____

Others YES NO _____

Is the child currently taking, or have taken any medications for psychological reasons?

_____

Does the child have chronic health conditions? If so, please explain:

_____

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 and 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 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 coverage.

Your Responsibility

If Your Insurance Does Not Cover Services

If your insurance does not pay for the 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, the payment is due at that time. For your convenience we ask that you put a credit card on file.

Change in Insurance Coverage

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

Late Cancellations and No Shows for Appointments

We understand that things occasionally arise at the last minute and we make every effort to consider that. However, it is the **policy of this office to charge $125 for missed appointments and no shows. Please call to cancel 24 prior to your appointment.**

Account Balances

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

Forms and Letters

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

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

Signature _____ Date _____

TULSA FAMILY DEVELOPMENT CENTER

CONSTENT TO USE AND DISCLOSE YOUR PROCTECTED HEALTH INFORMATION AND CONFIDENTIALY 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 are 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 sent it to others, **with your permission**. Our Notice of Privacy Practices explain your rights in more details and how we and share your information.

As a client seeing a psychologist, one of your most important rights involves confidentially. Within certain limits, information revealed to 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 with 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 content for treatment. Also, by signing this form, you are agreeing to let us use your information in this office and send it to others.

Date Signature of Client or Personal Representative

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_____