Paul Beljan, PsyD, ABPdN, ABN
Laura Wingers, PsyD
Vanessa Berens, PhD
Casey Heinsch, MAS, LAMFT
Sarah Bald, PsyD, Post-Doctoral Fellow

Beljan Psychological Services

9835 E. Bell Rd., Ste. 140
Scottsdale, AZ 85260
(602) 957-7600
www.beljanpsych.com

Beljan Psychological Services
Family Psychotherapy Intake Form

Today's date:_____

INFORMATION:

Parent A: _____ Date of Birth: _____ Age: _____

Home Address: _____ City_____ ST ____Zip_____

Phone: HM:_____ C: _____

Email: _____

Occupation: _____ Education: _____

Parent B: _____ Date of Birth: _____ Age: _____

Home Address: _____ City_____ ST ____Zip_____

Phone: HM:_____ C: _____

Email: _____

Occupation: _____ Education: _____

You are: single married separated divorced re-married widowed

CHILDREN:

Name: _____ Date of Birth: _____ Age: _____

biological closed adoption open adoption step-child foster child

Name: _____ Date of Birth: _____ Age: _____

biological closed adoption open adoption step-child foster child

Name: _____ Date of Birth: _____ Age: _____

biological closed adoption open adoption step-child foster child

Name: _____ Date of Birth: _____ Age: _____

biological closed adoption open adoption step-child foster child

Others living in the house:_____

Family Information

Briefly describe the main reasons you are seeking services.

_____

_____

_____

How long has the problem been an issue? _____

What have you tried to address the concern? _____

_____

What worked best? _____

_____

What has not worked? _____

What do you hope to will happen through this process? _____

Child(ren) Health History: (circle all that are that apply to all children):

☐ Depression	☐ Bipolar Disorder	☐ Neurological Illness	☐ Alcoholism
☐ Anxiety	☐ Schizophrenia	☐ Seizures	☐ Drug Abuse
☐ Suicidal Ideation	☐ Personality Disorder	☐ Attention Problems	☐ Legal Problems
☐ Obsessive-Compulsive Dis.	☐ Psychiatric Disorder	☐ Learning Difficulties	☐ Incarceration

☐ Other: _____ ☐ Other: _____

Please explain: _____

Current Medications/Supplements (Please include Dose, Reason, and Prescribing Physician):

_____

_____

_____

List serious illnesses/injuries/hospitalizations/surgeries

Date Incident (explain)

_____ _____

_____ _____

_____ _____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Parent A Health History: (circle all that are that apply):

☐ Depression	☐ Bipolar Disorder	☐ Neurological Illness	☐ Alcoholism
☐ Anxiety	☐ Schizophrenia	☐ Seizures	☐ Drug Abuse
☐ Suicidal Ideation	☐ Personality Disorder	☐ Attention Problems	☐ Legal Problems
☐ Obsessive-Compulsive Dis.	☐ Psychiatric Disorder	☐ Learning Difficulties	☐ Incarceration

☐ Other: _____ ☐ Other: _____

Please explain: _____

_____

Current Medications/Supplements (Please include Dose, Reason, and Prescribing Physician):

_____

_____

_____

List serious illnesses/injuries/hospitalizations/surgeries

Date Incident (explain)

_____ _____

_____ _____

_____ _____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Parent B Health History: (circle all that are that apply):

☐ Depression	☐ Bipolar Disorder	☐ Neurological Illness	☐ Alcoholism
☐ Anxiety	☐ Schizophrenia	☐ Seizures	☐ Drug Abuse
☐ Suicidal Ideation	☐ Personality Disorder	☐ Attention Problems	☐ Legal Problems
☐ Obsessive-Compulsive Dis.	☐ Psychiatric Disorder	☐ Learning Difficulties	☐ Incarceration

☐ Other: _____ ☐ Other: _____

Please explain: _____

_____

Current Medications/Supplements (Please include Dose, Reason, and Prescribing Physician):

_____

_____

_____

List serious illnesses/injuries/hospitalizations/surgeries

Date Incident (explain)

_____ _____

_____ _____

_____ _____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Does anyone else in your family have difficulties or problems similar to your reason for referral? Y / N

Please explain: _____

Has anyone in the family experienced: (circle all that apply):

Death of a loved one Separation from a loved one Emotional trauma Family conflict

Domestic Violence Physical abuse Emotional Abuse Sexual Abuse/Sexual Assault

Please briefly explain:

_____

_____

_____

Describe your parenting style:

_____

_____

_____

Describe the emotional needs of your child(ren):

_____

_____

_____

Describe, in detail, the problematic behaviors related to the problem:

_____

_____

_____

List family strengths and weakness:

_____

_____

_____

Briefly describe your family dynamic:

_____

_____

_____

Please describe any other important information:

_____

_____

_____

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I have received a copy of:

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

_____ _____

Patient's Name Guardian's Name (if patient is a minor)

_____ _____

Patient or Guardian Signature Date

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I understand that **Casey Heinsch** is a Licensed Associate Marriage and Family Therapist under the supervision of licensed psychologist Paul Beljan, PsyD, ABPdN, ABN and Vanessa Berens PhD at Beljan Psychological Services. I understand that my therapist receives additional outside clinical supervision from Shannon McQuaid, LMFT, LISAC.

The goal of supervision is to enhance professional development to uphold standards required of the licensed psychotherapy professional. Supervisors are bound by the same confidentiality as the therapist. With your consent, the supervisors will have access to your confidential information and records for reviewing with the therapist.

Through the course of supervision the therapist may request the use of audiotaping or live supervision sessions. If a request is made, you will receive a written formal request in advance. Live supervision and/or audiotaping will be used for the purpose of the therapist's professional development. You always have the right to decline the request for live or audiotaped supervision.

By signing this form I am agreeing to allow any of the aforementioned therapist to provide psychotherapist services under the supervision of the aforementioned supervisors to my child or myself (whichever is applicable) as a part of treatment services.

I understand that I may contact at Beljan Psychological Services (602) 957-7600 or Shannon McQuaid (602) 509-1592 with any questions or concerns at any time.

_____	_____
Patient's Name	Guardian's Name if patient is a minor
_____	_____
Patient or Guardian's Signature	Date
_____	_____
Clinician's Signature	Date
_____	_____
Supervisor's Signature	Date

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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice which is attached to this Agreement explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at anytime. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES AND FEES _____ (initial)
Our practice offers neuropsychological assessment, psychoeducational and gifted intellect assessment, psycho-diagnostic sessions, psychological assessments, and psychotherapy. Neuropsychological evaluations typically require 6 to 10 hours from diagnostic interview through the feedback session. The flat rate fee for our full neuropsychological assessment is $2,500.00. Psychoeducational and gifted intellect assessments usually take between 3 to 6 hours. The fee for psychoeducational assessment is $225.00 per hour. Our gifted assessment rates are available upon request. For a diagnostic interview we charge $225.00 per hour. If it is decided to proceed with a full neuropsychological evaluation the cost from the diagnostic interview will be applied to the flat fee cost. We are available to attend school meetings for $150.00 per hour door to door. For consultations we charge $195.00 per hour.While report writing is included in the assessment fee, letter writing is an additional 100.00 per hour. Psychotherapy session rates are available upon request. Record review is $225.00 per hour and does not apply to the flat fee for neuropsychological evaluations. Forensic fees are available upon request.

A ‘no-show’ is defined as failure to cancel a scheduled appointment 24 hours prior to the appointment or completely failing to show for a scheduled appointment. Our no-show fee is $150.00 per incident. Additionally, we require a non-refundable $300.00 retainer before we will schedule another appointment if a client cancelled/no-showed two consecutive appointments. By signing this Agreement, you agree to comply with this policy.

Late policy: It is our priority to spend quality time with each patient. We cannot accommodate a patient who is more than 15 minutes late for a psychotherapy session, as this will affect other patients. If you are 15 minutes late, we will not be able to see you, and you will be responsible for payment in full.

I understand that the professional is providing clinical, not forensic services. I further understand that as there is as at least a potential and more likely an actual conflict of interest in a psychologist or psychotherapist providing clinical and forensic services in the same case the professional will not provide any forensic services to or for client. If called to testify in a legal setting, and subject either to a written authorization or a court order to release confidential information, the professional will report as a witness to the extent asked about the facts involved in the clinical services provided, including if asked the opinions reached in the course of the clinical work. The professional will not perform any analysis or provide any opinions for the express purpose of addressing issues arising in the legal setting.

CONTACTING BPS

Our office hours are 9 AM to 5 PM, Monday thru Friday. Although our phone lines are only open from 9AM to 4PM. If no one answers leave a message with detailed information and we will return your call at least by the next business day. If you are difficult to reach, please include in your message the most favorable times we can contact you. The clinical staff also finds it efficient to set phone appointments to insure timely contact. If you are unable to reach us and feel that you cannot wait you can call the **Maricopa Crisis Line @ 1-800-631-1314** or contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

LIMITS ON CONFIDENTIALITY _____ (initial)

The law protects the privacy of all communications between a patient and a psychologist or psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require you provide written advance consent. Your signature on this agreement provides consent for those activities, as follows:

- We may find it helpful to consult other medical and mental health professionals about a case. During a consultation we do not reveal the identity of the patient. The other professionals are also legally bound to keep the patient information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health and allied health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member who has prior written authorization. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient threatens to harm himself\herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

Situations occur where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and request is made for information concerning the professional services we provided you, such information is protected by the psychologist/ psychotherapist -patient privilege law. We cannot provide any information without you or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

- If a patient files a worker's compensation claim, and we are providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations may include:

- If we have reason to believe that a minor who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires us to file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires us to file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim including themselves, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

In the event of the death or incapacitation of your clinician:

- Each clinician has a professional will and in the event of their death or incapacitation, their professional executor has access to your records for the sole purpose of securing them, providing any needed notifications, and arranging for their storage/access for the statutory period.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

Due to HIPPA, confidentiality, and the ethical duty to protect testing materials, BPS does not allow audio or visual recordings done in any way or using any format of the testing, assessment, feedback, or psychotherapy sessions. The term "audio recordings" includes, but is not limited to, recording an individual's voice using video recording (e.g., video cameras, cellular telephones), tape recorders, or other technologies capable of capturing audio. The term "visual recording" includes, but is not limited to, recording an individual's likeness (e.g., image, picture) using photography (e.g., cameras, cellular telephones), video recording (e.g., video cameras, cellular telephones), digital imaging (e.g., digital cameras, web cameras), or other technologies capable of capturing an image (e.g., Skype, Facetime). Considering the development and growth of technology other means may exist or come into existence for recording in some other way testing, assessment, feedback, or psychotherapy sessions; this notice prohibiting recording is intended to extend to any and all such means, without exception. If you have any question about whether this notice applies to anything you have done, are doing or are considering doing then you must immediately notify the person conducting the testing, assessment, feedback, or psychotherapy sessions so the matter of recording can be addressed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. This accessibility does not extend to testing protocols, because of test security issues. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying, postage, and administrative fee.

PATIENT RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS
Patients under 18 years of age (minors) who are not emancipated from their parents should be aware that the law may allow parents to examine their treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else; in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS _____ (initial)
You will be expected to pay for each session at the time it is held, unless we agree otherwise. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, all costs will be included in the claim and be the responsibility of the patient.

INSURANCE REIMBURSEMENT _____ (initial)
This is a fee for service practice. We do not accept insurance. If you wish to submit a claim to your insurance company, we will provide you with a diagnosis page and CPT codes. All insurance companies claim to keep such information confidential; we have no control over the use of the information once it has been submitted to the insurance company. By signing this Agreement, you agree that we can provide requested information to your carrier.

PREFERRED & ACCEPTABLE CONTACT
Please specify your preferred form of contact:

Telephone: _____Type:_____

Email:_____

Mail:_____

Our standard practice is to provide patients with appointment reminders via telephone or email contact. These reminders include: the patient's name, the name of our practice (Beljan Psychological Services) and/or the name of the professional with whom you have an appointment, the date and time of your appointment, and our telephone number. We will not disclose PHI in voicemail messages left on your cellular, home, or office phones unless you specifically authorize us to do so.

If you would like us to leave appointment reminders via voicemail, please specify the telephone number at which appointment reminders may be left. _____

APPROVAL GIVEN
By signing this agreement you give us the permission to treat you or your child in accordance with the

information stated in this document. This treatment includes but is not limited to neuropsychological assessment, psychoeducational/intellectual assessment, psychotherapy, and other treatments previously discussed and agreed upon with the patient and/or guardian.

SIGNATURE

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. In cases of joint custody, we will need to have signatures from both parents and/or legal guardians before we can proceed with testing your child. In cases of divorce, we also need a copy of the custody agreement before we can work with the child.

_____	_____
Patient's Name	Guardian's Name if patient is a minor
_____	_____
Patient or Guardian's Signature	Date