CHERYL M. BEACH, Ph.D.

PATIENT REGISTRATION INFORMATION

Patient Name _____ Sex: M or F _____ Date of Birth _____

Home Address _____
Street City State Zip Code

Email: _____

Phone (H) ( ) _____ (W) ( ) _____ Cell or Other _____

Is it OK to call and leave messages at both numbers? ☐ Yes ☐ No Please circle number to call first.

If no, how may we contact you? _____

Responsible Party (if not the patient) _____

Relationship to patient _____

Responsible Party Address _____
Street City State Zip Code

Phone (H) ( ) _____ (W) ( ) _____

Patient School / Work Address _____ Full or Part-time

_____
Street City State Zip Code

Primary Care Physician _____ Address _____

Phone ( ) _____ Who referred you? _____

BILLING INSTRUCTIONS

Your signature expresses your agreement that the dates of service, services rendered, and diagnosis will be provided to office staff for administrative and billing purposes only. Signature also indicates liability for any balance due, with the understanding that Dr. Beach is not a member of insurance panels and does not bill insurance for evaluation. The patient's or responsible person's signature below authorizes release of any medical information for these purposes and authorizes payment to be made directly to supplier of the service.

Signature _____ Date _____

FOR OFFICE USE: Diagnosis: _____

Cheryl M. Beach, Ph.D.
Clinical Psychologist

1117 Fehl Lane
Cincinnati, OH 45230

3001 Highland Avenue
Cincinnati, Ohio 45219
(513) 961-8484

CONSENT FOR PSYCHOLOGICAL TREATMENT OR ASSESSMENT

Name _____ Birth date _____

Psychological treatment is provided based on the needs of the client and the client's family. Benefits include improvement in mood, behavior, academic or work performance, and/or family functioning. The benefits from assessment include gaining potentially valuable information about function in these areas. On occasion, psychological treatment can result in difficult changes for the client or the family. These difficulties, although occurring rarely, nonetheless constitute a risk to the client. Possible risks include, but are not limited to, worsening of behavior, mood or school/work performance, or worsening of family functioning.

There are also risks involved in refusal of therapy or assessment. These include possible increased problems for the client at home, work, and/or school because relatively limited information is available regarding emotional, academic and/or occupational functioning. Benefits associated with refusal of treatment are that little effort need be expended by the client or family and problematic behavior may remit on its own. If you decline therapy or assessment, I will work with you to facilitate a referral elsewhere. It is your right to refuse treatment now or at any point during therapy or the assessment process.

Confidentiality

Issues discussed during the course of therapy or assessment with a psychologist are confidential, meaning that the information you reveal will not be discussed with others without your knowledge and consent. However, you need to be aware of certain circumstances where there are exceptions to confidentiality: in situations of potential harm to other or oneself (for example, suicide), when there is reason to suspect child abuse or neglect, including sexual abuse, and in instances where the court subpoenas records. In these circumstances, the release of confidential material by the therapist is, or may be, required by law. At any time, you may waive the privilege of confidentiality and request that some information be discussed with another person (for example, other professionals or family members).

Regarding therapy with children and adolescents: although parents may have a legal right to information in medical records, success in therapy may be limited if the parents do not agree to allow the child or adolescent to have a confidential relationship with the therapist. By signing below, you indicate that you agree to allow this and you will not ask the therapist to share information that the child does not wish to release. Of course, the above-described limits to confidentiality still apply.

I do my best to protect your privacy. Filing for insurance treatment authorization or fee payment requires me to assign a psychiatric diagnosis and provide history and treatment details even though I am not a contracted "panel provider" for any insurance company. I do not have any contractual fee reductions with insurance companies, and you are responsible for fees. Your signature below releases me to share information in order to request insurance authorization when necessary and collect fees, including insurance billing.

****

I hereby authorize Cheryl M. Beach, Ph.D. to provide psychological services to the above named person. Having read and understood the above, I agree to the limits of confidentiality.

Signature _____ Date _____

Parent or Guardian Signature _____

Cheryl M. Beach, Ph.D.
3001 Highland Avenue
Cincinnati, OH 45219
(513) 961-8484 Fax: (513) 487-3760

Health History

Name _____ Date of Birth _____

Please complete the following information. If you prefer not to respond to certain questions, feel free not to respond. Thank you.

Primary Care & Referring Physician _____
Approximate date of last medical exam _____

Please indicate any history or current treatment for any significant illness or medical conditions.

_____

_____

Do you have any physical problems about which you are concerned not listed above?

_____

_____

Do you have allergies or adverse reactions to medications?

_____

_____

What medications are you currently taking?

_____

_____

Substance Usage:
Approximate daily use of caffeine: _____
Approximate daily use of tobacco: _____
Approximate daily use of alcohol: _____
Approximate daily use of marijuana or other psychoactive substances: _____

Have you had prior medical consultation or treatment for the present concern? (Please specify the type, with whom and approximate dates:

_____

_____

_____

CHILD PATIENT INFORMATION

Parent's marital status: _____

If parents are widowed, divorced or separated, please describe status: custody, parenting arrangement, dates of transitions:

_____

_____

Please indicate any other developmental or medical concerns:

_____

_____

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Cincinnati, Ohio 45230

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Cincinnati, Ohio 45219

(513) 961-8484

I was offered the opportunity to read Office Privacy Policies and Procedures for Cheryl M. Beach, Ph.D.

Name _____
(Please print patient name)

Signature _____
(Patient and / or responsible party please sign)

Date _____

Cheryl M. Beach, Ph.D.
Clinical Psychologist

3001 Highland Avenue
Cincinnati, OH 45219

(513) 961-8484 FAX 513 487-3760

RELEASE OF INFORMATION

I hereby give permission to Cheryl M. Beach, Ph.D. to release information to:

_____ about the evaluation and/or treatment of the medical, psychological or substance use conditions of _____, whose date of birth is _____.

This information is to be used only for the purposes of:

--gathering information for treatment planning _____yes _____ no

--other _____

I also give permission for exchange of information between both parties

_____ Yes _____ No

I understand that by State and Federal law (1) only the specified information can be released to the specified recipient and (2) I may revoke this authorization at any time in writing; revocation has no effect on prior action. This release will expire 180 days from the signature date unless specified otherwise. The release of any information concerning AIDS, HIV infection or AIDS-Related Complex is authorized unless specifically excluded.

_____

Signature

_____

Date

_____

Guardian (if indicated)

Prohibition of Re-disclosure: Federal law (42CFR, part 2) prohibits re-disclosure of any of the above information except with specific written consent by the person to whom it pertains. A facsimile of this signed document may be accepted in lieu of the original.

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Billing Policy and Fees for Psychological Evaluation

A competent, legally defensible comprehensive psychological evaluation is a highly specialized service that requires a significant amount of professional time and expertise to produce. For every hour of direct patient contact during the evaluation, two or three additional hours are spent scoring tests, integrating and interpreting results, and preparing a comprehensive written document with recommendations for use by other agencies such as schools or referring physicians.

All evaluations are private pay, meaning the patient is directly responsible for payment. Payment is due, in full, at the time of service, that is, on the day of the evaluation. This office does not file insurance claims for services related to evaluations.

Dr. Beach will provide a receipt for anyone who wishes to seek reimbursement for their expenses from an insurance company. She will cooperate in any way that is reasonable, legal, and ethical to assist you in filing your insurance claim. However, you should be aware that many insurance companies do not cover evaluation and related services, especially when the assessment includes a possible learning disability or ADHD. The claim may be covered when the assessment indicates a psychiatric diagnosis.

Dr. Beach does not accept the insurance contractual write-off for the evaluation and the fees for related services. Dr. Beach feels that she is best qualified to determine the scope and quality of the evaluation needed for the patient. The type of service provided by this office goes beyond the typical service upon which the managed care and insurance companies base their usual and customary fee schedules. It is for this reason that evaluations are performed on a self-pay basis.

My administrative assistant manages billing; please contact her at the above telephone number re: billing questions, concerns, and needs. Payment is accepted by check or cash. We regret we are unable to accept credit card payments for evaluation services. Payment is expected at the time of service.

Your signature below indicates you understand and agree to pay for the full cost of the evaluation and related services. Your signature also indicates that you understand you may not be able to gain insurance reimbursement for these services and you still elect to have the services performed.

Signature _____ Date _____

Evaluation Fees

The cost of an evaluation is difficult to estimate because there is variability due to patient age, the reason for the evaluation, etc. A rough estimate is $5,500.00-$9,000.00 with additional expense if, for example, Dr. Beach is asked to travel off-site to attend meetings or to schedule lengthy telephone meetings on the patient's behalf. Testing for graduate and professional entrance and licensure boards tends to require additional testing and thus, the cost is typically higher.

Initial Session **Fee:** $400.00 per session

To obtain background information, complete an initial diagnostic assessment, and plan intervention.

Assessment, Interpretation, and Report **Fee:** $850.00 per hour spent with the client

A typical assessment involves about seven to eight hours with the client. The hourly rate includes time Dr. Beach spends directly with the client, and the additional time she later spends scoring tests, interpreting the meaning and significance of results, formulating an interpretation and diagnostic impression, developing recommendations, and preparing an exceptionally detailed written report. An associate may administer some tests under Dr. Beach's supervision.

Meet to Discuss Evaluation Results **Fee:** $300.00 per hour / $600.00 for a 2 hour session

Dr. Beach meets with the client, unless a referring therapist or doctor prefers to communicate the results. In most cases, Dr. Beach recommends two hours for this session. Additional time can be scheduled at your request.

Additional Consultation and Travel **Fee:** $220.00 per hour

Consultation may involve off-site meetings or extended phone time with family or other professionals (physicians, schools, etc.), at your request. There is no charge for occasional, brief telephone calls (5-10 minutes). If I must leave my office and travel to attend a meeting at a school, hospital, etc., a fee is charged based on "door-to-door" travel time.

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