CHERYL M. BEACH, Ph.D.

PATIENT REGISTRATION INFORMATION

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

Home Address _____
Street City State Zip Code

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

Anderson Professional Centre
7794 Five Mile Road, Suite 290
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:

Cheryl M. Beach, Ph.D.

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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 _____

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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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Fees for Psychotherapy

Initial Session.....Fee: $400.00 per session
To obtain background information, complete an initial diagnostic assessment, and plan intervention.

Psychotherapy Session.....Fee: $220.00 per 45-minute session
A psychotherapy session is 45 minutes in duration. An additional 15 minutes is used for administrative purposes. After-hours urgent and emergency calls are billed at this rate. Missed appointments and cancellations made with less than 24 hours notice are billed.

Therapeutic Consultation..... Fee: $220.00 per 45 minute session
Therapeutic Consultation includes attendance at off-site meetings or extended telephone contact on behalf of psychotherapy or evaluation patients. The consultation may be with family or other professionals (such as schools, physicians, etc.), and it is at patient request and / or acute clinical need. There is no charge for occasional, brief telephone calls.

Professional Consultation..... Fee: $220.00 per 45 minute session
Professional Consultation includes clinical supervision of other clinicians, such as social workers, psychologists, and psychiatrists. This procedure code also includes professional consulting for individuals regarding strategies to optimize academic learning and occupational performance (not necessarily related to a psychiatric diagnosis). In either case, the process involves reviewing records, performing research, developing recommendations.

Travel .....Fee: $220.00 per hour
To attend off-site meetings at a school, hospital, legal hearing, etc., "door-to door" travel time is billed at the rate of a therapy hour.

Regarding Insurance Billing

Your billing statement contains all of the information required for insurance company reimbursement if you have out of network insurance benefits. Many people have an "out-of-network" benefit that pays part of the fee, and my billing office can help answer any questions. My professional services are provided in good faith, with the understanding that you assume responsibility for payment of fees. If you have a question about fees or billing, or this presents a financial hardship, please discuss it with me.

Annual Increase
To offset the annual increase in practice management expense, you may anticipate an annual increase of $5.00 per year in the fee for one session of psychotherapy.

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BILLING POLICY FOR PSYCHOTHERAPY

Many patients ask about office policy regarding billing, payments, and insurance. I believe that patients should know what is expected from them and what they can expect from my office. I have put together this written policy for your information. My billing office can be reached at 513 961-8484. If you need assistance with insurance or other billing matters before your first visit, or at any future time, they are available to assist you.

1. Payment is always expected at the time of service unless other, prior arrangements are made.

2. Payment is accepted in the form of checks, money orders, and cash. Returned checks are assessed a fee equivalent to what my bank charges me. Psychological services are HAS-eligible medical services. I also accept Visa, Mastercard and Discover.

3. Your first visit has a higher fee ($400.00) to cover the additional time required to gather clinical history along with the clerical time needed to establish you as a new patient. Thereafter, the fee for psychotherapy is $200.00 per session. One session of psychotherapy is made up of 45 minutes of actual contact time. These fees are within the usual and customary range for this area. For more details, please refer to the Psychotherapy Fee list.

4. If you must cancel an appointment, please give a 24-hour notice. This is required so that others can have access to that appointment time. Missed appointments without cancelling are billed at full fee. Late-cancellations (less than 24 hours notice) are billed at $200.00. Insurance companies do not reimburse this charge and you are responsible.

5. Accounts that are not paid will be placed with a collection agency and I reserve the right to pursue collection. A finance charge (10%) is added if a balance accumulates beyond 90 days to cover the cost of account maintenance.

Please note the following if you intend to use health insurance:

6. If using health insurance, you must follow any required referral or pre-authorization procedure before your first visit. Please contact your insurance company to obtain approval for the visit before we meet. If charges are denied due to oversights on your part, including failure to obtain authorization, you are responsible for all charges.

Please ask me if you have a question about the financial policy. Please contact my billing office **(513) 961-8484,** with any questions about your insurance, billing statements, or your account.

The purpose of providing this written statement of financial policy is to address frequently asked questions about billing from the outset. This allows more time during your visit to focus on treatment issues. Your signature below indicates your understanding and agreement with this policy.
There are two copies of this document; please sign both, return one to the office and keep one for your reference.

Name _____ Date _____

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