Paul Beljan, PsyD, ABPdN, ABN
Vanessa Berens, PhD
Kate Haskew, CAGS, NCSP, ABSNP
D. Weaver, PsyD, Post Doctoral Fellow

Beljan Psychological Services

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

PEDIATRIC INTAKE FORM

Today's Date: _____ Individual completing this form: _____

Child's Name: _____Date of Birth: _____ Age: _____

School: _____ Grade:_____

Home Address: _____ City_____ ST ____Zip_____

Individual who referred you/Relationship: _____ May we thank this person? Y N

Parent/Guardian Information

Parent: _____ Age:_____

Address (if different): _____

Daytime Phone: _____ Cell Phone: _____

Home Phone: _____ Secure E-mail: _____

Education: _____ Occupation: _____

Parent: _____ Age:_____

Address (if different): _____

Daytime Phone: _____ Cell Phone: _____

Home Phone: _____ Secure E-mail: _____

Education: _____ Occupation: _____

Parents' Marital Status: Not married Married Separated Divorced Widowed/Deceased

If separated or divorced: Who has custody? _____

Sole Custody? Y N *If yes, we will need legal documentation before providing services.*

Joint Custody? Y N *We will need both parents' consent and signatures before providing services.*

Child is: Biological Adopted (at age _____) Foster Other arrangement _____

Siblings (Names/Ages): _____

_____

Others Residing with Child: _____

Nanny/Caregiver/Day Care: _____Schedule/Hours per day?_____

Does the child prefer one parent over the other? Y N Which one? _____

Why? _____

Referral Information

Referral Reason (Briefly describe the main reason you are seeking help for your child):

_____

_____

_____

Describe some of your child's strengths/abilities: _____

_____

_____

Describe some of your child's weaknesses/difficulties: _____

_____

_____

Do both parents agree about the nature and causes of the concern? _____

Please explain: _____

_____

What have you tried to address the concern: _____

_____

_____

What has worked best? _____ Worst? _____

_____

How do you discipline your child? _____

What is the result? _____

_____

What do you hope to learn as a result of this evaluation? _____

_____

Social/Emotional/Behavioral History

My child: (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please describe any pertinent issues regarding your child's social/emotional/behavioral functioning:

_____

_____

_____

What do you find most difficult about your child's social/emotional/behavioral functioning?

_____

_____

Does your child make and maintain friendships? Y N Does your child have any close friendships? Y N

Please explain: _____

_____

What does your child love? _____

What does your child dislike? _____

What are your child's current activities and/or interests **(**particular topics, themes, sports, lessons, club involvement, etc.)? _____

_____

Have there been any events in your child's or family's life that have been difficult for your child to handle or get used to? Please explain:

_____

_____

Other information relevant to your concerns about your child: _____

_____

_____

_____

Educational History

Current school/How long attended: _____

Other schools attended/grade(s): _____

Current Grade: _____ Placement: Gifted Regular Special Education Related Services

Other (please describe)_____

Any grades skipped? _____ repeated? _____

Teachers report strengths in: _____

Teachers report concerns/problems in: _____

_____

Reading	Spelling	Mathematics	Writing
Inattention	Behavior	Social Adjustment	Hyperactivity
Impulsivity	Distractibility	Motor Skills	Other: _____
Organization	Work Completion		

Please describe academic and/or behavioral concerns: _____

_____

_____

Grade:	Academic Performance (Please describe)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do teachers report concerns that you do not notice or agree with? Please describe: _____

_____

_____

Do you see concerns that teachers don't notice or agree with? Please describe: _____

_____

_____

_____

_____

Pregnancy and Birth History

Age of mother at delivery: _____ Age of father at delivery: _____

Number of prior pregnancies: _____

Number of prior miscarriages: _____Was a fertility specialist consulted? _____

Living circumstances during pregnancy: _____

_____

Health problems of mother/pregnancy complications? _____

(circle all that apply):

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Mental Illness
Physical Abuse	Sexual Abuse	Spousal abuse:	Emotional Abuse
Sexually Trans. Disease	Other:	Other:	Other:

Medications, alcohol/tobacco/drug use during pregnancy? _____

Delivery: Vaginal Cesarean Induced Full Term Premature Gestational age: _____

Birth Weight: ____ lbs. ____oz Time spent in labor: _____hours

Circle any birth complications that apply:

Breech	Cord around neck	Meconium staining	Lacking oxygen
Jaundice	Fetal Distress	Forceps/Vacuum	Other: _____

Please explain any medical problems/other difficulties after delivery or in first year of life, and interventions required: _____

_____

Did mother experience postpartum depression? Y N Duration/severity? _____

Developmental History

Motor Developmental Milestones:

Age sat alone: _____ crawled: _____stood alone:_____ walked alone:_____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?) Y or N Explain:_____

Handedness: Right Left Ambidextrous (both)

Any physical or occupational therapy services your child has received (at what age/duration of services):

_____

Speech/Language Developmental Milestones:

Child's first language _____ Language spoken in the home _____

Age spoke first word _____ put 2-3 words together _____ full sentences _____

Circle all that apply:

Speech/language delays	Stuttering	Hard to Understand	Late Drooling
Poor Sucking	Poor Chewing	Articulation Problems	Slow to learn alphabet
Slow to learn colors	Slow to learn counting	Frequent Ear Infections	Other: _____

Any speech therapy services your child has received (at what age/duration of services): _____

_____

Toileting:

Age when toilet trained_____ Problems with: Bedwetting Urinating Soiling

Current Problems? Explain: _____

Medical History

Child's Pediatrician/Contact Information: _____

_____

Last Vision Exam: _____ Any problems: _____

Last Hearing Exam: _____ Any problems: _____

Allergies/Asthma? Y N Please describe: _____

Does your child take medication and/or supplements on a regular basis? Y N

List medications and/or supplements taken, reason, since when, and prescribing physician, if any:

_____

_____

Any history of: Head Injury Seizure Loss of Consciousness Please explain:

_____

List serious illnesses/injuries/hospitalizations/surgeries: _____

_____

Describe your child's sleep, diet, and exercise habits, and any concerns: _____

_____

_____

Does your child have particular sensitivities (i.e., noise, food, tags on clothing, etc.)? _____

_____

Has your child experienced any of the following conditions? (circle all that apply)

Failure-to-thrive	Febrile seizures	Epilepsy	Staring spells
Head injuries	Meningitis	Encephalitis	Asthma
Allergies	Diabetes	Loss of Consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties
Sleep walking or talking	Eating difficulties	Eating disorder	Facial or other Tics
Repetitive movements	Impulsivity	Temper tantrums	Nail biting
Clumsiness	Head banging	Self-injurious behavior	Other: _____
Physical injuries	Lead poisoning/toxic ingestion		Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above: _____

_____

_____

Psychological and Treatment History

Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning Difficulties	Attention Problems	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide	Alcoholism	Drug Abuse
Legal Problems	Other: _____	Obsessive-Compulsive Disorder	Personality Disorder

Please explain: _____

_____

Child History: Has your child experienced *(circle all that apply):*

death of a loved one separation from a loved one emotional trauma marital conflict
family conflict sexual abuse physical abuse emotional abuse
Please explain:_____

_____

_____

_____

Evaluation and/or Treatment History: List any current and past treatment by psychologists, psychiatrists, counselors, or other service providers in the school or community. Include results of previous medical, psycho-educational or neuropsychological evaluations and any tests given. Indicate dates and names of providers/agencies.

_____

_____

_____

_____

_____

_____

_____

Is there anything else you believe it is important for us to know?

_____

_____

_____

_____

_____

Thank you!

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PSYCHOLOGIST/CLINICIAN-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.

PAYMENT IS DUE AT TIME OF SERVICE_____(initials)

I understand that payment is due at the initiation of services. We can accept payment in full at the time of the first appointment OR we can take half of the required payment at the initial appointment and half at the final appointment. Services are considered complete at the final appointment, not when the report is generated. _____ **(initials).** If a third party outside of the patient or guardian is going to be paying for services rendered they will be required to fill out the consent for payment form with a credit card form and charges will be processed at the time of service initiation.

PSYCHOLOGICAL SERVICES AND FEES _____ (initial, if applicable)

Our practice offers neuropsychological assessment, autism assessment, 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 between $3,500.00- $3,950.00. Gifted intellect assessments usually take 3 hours. Our gifted assessment ranges from $500.00- $750.00. Our psychological evaluation is a flat rate of $2,250.00. We offer a variety of other testing options as well on an a la carte basis, which we can discuss with you upon learning more about the patients needs. Our

autism evaluations range from $800.00-$1,975.00. A cost and time estimate for specific services is available upon request. For a diagnostic interview we charge $260.00 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 $260.00 per hour door to door. Consultation meetings for advocacy are $260.00 per hour, this fee will include standard records review. In the event that significant time is warranted for records review we will inform you of the associated fees. For consultations we charge $260.00 per hour. While report writing, scoring, and interpretation is included in the assessment fee, letter writing is an additional 125.00 per hour. Record review is $260.00 per hour and does not apply to the flat fee for neuropsychological evaluations. Forensic fees are available upon request.

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.

IN CASES OF DIVORCE, CUSTODY, LEGAL
(Please complete "Informed Consent in Cases of Divorce/Shared Custody")

In cases of sole custody please bring a copy of the decree/legal documentation for our records.

I understand that in cases of divorce where parents share custody, we require both parties initials and signatures on all documents. I understand that Beljan Psychological Services cannot see my child without this _____**(initials)**

FAILURE TO CANCEL APPOINTMENTS/NO SHOWS & LATE POLICY ____(initials)

I understand that a 'no-show' is defined as failure to cancel a scheduled appointment 24 business hours prior to the appointment or completely failing to show for a scheduled appointment. Our no-show fee is $150.00 for the first incident and can amount to the total cost of your session for each additional incident. Additionally, we require a non-refundable $300.00 retainer before we will schedule another appointment if two consecutive appointments are not canceled within our required time frame.

If a client no-shows or reschedules two or more consecutive recurring appointments they understand that they will be removed from the recurrence and are able to schedule appointments on a weekly/as needed basis.

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.

PSYCHOTHERAPY SERVICES AND FEES _____ (initial, if applicable)

Our practice offers initial psychotherapy assessments and psychotherapy services for individuals, couples, and families. Initial appointments typically require a minimum of 1 hour and up to 2 hours. The

ongoing sessions are typically 50 to 60 minutes. Longer sessions will be discussed and determined by the client and the clinician prior to scheduling if they are needed. The fee for service from a student is $145.00 per hour. For a master's level clinician and above rates range from $195.00-$250.00 per hour. A credit card form is required to be completed and placed on file for services rendered for psychotherapy. If at any time you wish to change the card on file please contact us prior to your next session _____ **(initials).** Some clinicians are available to attend school meetings at the predetermined session rate. Additional contact, letter writing and evaluations fees are previously discussed between the client and the clinician, as they may vary based upon the clinician. Specific modalities of treatment are based upon the clinician's training and licensing.

I understand that if I haven't been in contact with Beljan Psychological Services for 45 consecutive days my file may be closed. I further understand that I am able to call to re-establish services with Beljan Psychological Services based on availability and I will be required to complete paperwork. Costs are subject to change.

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 through 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 by the next business day (this does not include holiday hours). 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 schedule phone appointments to ensure timely contact. We have an office cell phone **(602) 396-8358** that is monitored, but if you need to reach us immediately, please call the main line **(602) 957-7600** and leave a voicemail. 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 HIPAA, 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, Zoom, 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.

USE OF ARTIFICIAL INTELLIGENCE (AI) TOOLS _____ (initial)

As part of your forensic, psychological or neuropsychological evaluation, this practice may use Artificial Intelligence (AI) based tools to support aspects of test scoring, data organization, medical dictation software, and report generation. These tools assist the psychologist by:

- Scoring standardized psychological measures
- Extracting or organizing structured information from interviews, records, or written materials

- Assisting with identifying and interpreting patterns in psychological or neuropsychological data (i.e. Pearson Clinical, PAR, WPS, Dragon Medical One, ChatGPT, etc.)
- Generating structured summaries or drafts for clinical review

AI tools are not used to make independent diagnostic or clinical decisions. All clinical conclusions, interpretations, and recommendations are made solely by the licensed psychologist conducting your evaluation. The psychologist reviews, verifies, and integrates all results using professional judgment and expertise.

Your personal information and test data are handled in accordance with all applicable privacy laws (including HIPAA) and professional ethical standards. AI tools used by this practice are bound by Business Associate Agreements (BAA) to ensure that all data handling complies with HIPAA regulations for privacy and security.

- The psychologist will take reasonable precautions to ensure that all personal and psychological data are protected.
- If AI tools are used, they will be selected based on their compliance with privacy standards such as HIPAA (Health Insurance Portability and Accountability Act) or applicable state and federal laws.
- Only the minimum necessary information is entered into AI systems for analysis or processing.
- Any data transmitted to or processed by AI tools is encrypted and stored securely.
- Information processed by AI tools will be anonymized or encrypted whenever possible to protect your identity.
- Your identifiable information is not shared with third parties beyond these secure, HIPAA-compliant systems.

MARITAL OR FAMILY COUNSELING _____ **(initial if applicable)**

By initialing above, you are agreeing to be a participant in marital or family counseling. There are meaningful differences between couples, family and individual psychotherapy. Couples and family psychotherapy includes the participating members as the "client. Individual psychotherapy involves only the identified client and the clinician,. First, in any session, the clinician is working to improve the relationship and interactions among the participants and, accordingly, will not have a duty to act for the benefit of any one participant over the interests of any other participant. Do not expect your clinician to take sides; it will be your responsibility to work through issues with your clinician's help. Second, matters discussed in session by one member cannot be kept confidential from the other members. While your clinician and our practice will maintain the confidentiality of information disclosed in session from outside persons as provided in HIPAA (subject to the Limits on Confidentiality described above), and will encourage all members to agree that what is said in session is not to be discussed outside of group or disclosed to others, neither your clinician nor our practice can control the use or disclosure of such information by other members and we have no responsibility or liability to you if such disclosure occurs. A credit card form is required to be completed and placed on file for services rendered. If at any time you wish to change the card on file please contact us prior to your next session _____ **(initials).**

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. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we reserve the right to use 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 and are not contracted with any insurance companies. We cannot submit paperwork for patients to obtain prior authorizations, as we are not contracted with any insurance companies. If you wish to submit a claim to your insurance company, we will provide you with a diagnosis code, if one is available 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 our clients. If you wish to submit to your insurance company, please let us know so that we can make sure to code your receipt(s) accordingly.

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

Telephone: _____Type:_____

Is Okay to Leave Voicemail: _____

Email:_____

Our standard practice is to provide patients with appointment reminders via telephone, text message, 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.

APPROVAL GIVEN
By signing this agreement, you give us 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. If at any given time any parent wants us to discontinue services, they need to contact Beljan Psychological Services directly to notify us.
_____**(initials)**

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.

_____ _____
Client or Guardian's Name Client or Guardian's Signature

_____ _____
Client or Guardian's Name Client or Guardian's Signature

_____ _____
Clinician's Name/Administrator Name Clinician's Signature/ Administrator Signature

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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 **Kate Haskew, CAGS**. is a Psychometrician under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

I understand that **Darci Weaver, PsyD** is a Post Doctoral Fellow under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

I understand that **Derek Chan** is a Psychology Doctoral Practicum Student under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

I understand that **Zachary Clang** is a Psychology Doctoral Practicum Student under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

I understand that **Lyana Sanchez** is a Psychology Doctoral Practicum Student under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

I understand that **Izhani Rosa** is a Psychology Doctoral Practicum Student under the supervision of licensed psychologist Paul Beljan, PsyD, at Beljan Psychological Services.

By signing this form I am agreeing to allow any of the aforementioned Post-Doctoral Fellow, students, and/or psychometricians to administer assessment measures under the supervision of the aforementioned psychologists to my child or myself (whichever is applicable) as a part of my child's or my evaluation (whichever is applicable).

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

_____ _____

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

_____ _____

Patient/Guardian Signature Date

Paul Beljan, PsyD, ABPdN, ABN
Vanessa Berens, PhD
Kate Haskew, CAGS, NCSP, ABSNP
D. Weaver, PsyD, Post Doctoral Fellow

Beljan Psychological Services

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Scottsdale, AZ 85260
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Informed Consent in Cases of Divorce/ Shared Custody

In cases of shared custody please look over this form carefully before signing. If we do not have this document signed by both parents at the time of service we will not be able to see your child for therapy, gifted testing, psycho-educational testing, or neuropsychological evaluations. In cases of sole custody please bring a copy of the decree/legal documentation for our records.

Divorce, Custody, or Legal Issues

As a mental health practice our primary focus, responsibility, and goal is the treatment and well-being of our identified patients. In the case of a child as the primary patient it is essential that parents and legal guardians who are not in conflict and are in fact in agreement as to the decision to treat, the treatment goals, appointment times, need to maintain patient confidentiality. The therapeutic process and assessment are a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means that you each agree as a condition of treating your child, assessing your child's emotions, or performing a neuropsychological evaluation, that:

- You shall treat anything that is said in any individual or group therapy session as strictly confidential;
- Our role is limited to providing treatment, assessing emotions, and/or performing a neuropsychological evaluation on your child and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- You shall not request or require us, through subpoena, summons, or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceedings relating to the care and custody of your child; and
- If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more Authorization to Release Information forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinicians time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure or treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements. We do not specialize in cases of custody.

For families of divorce and/or ongoing child custody issues, Beljan Psychological has the following policy:

- Any email sent to Beljan Psychological Services is to be contemporaneously sent (cc'd) to the other parent(s) and any other attorney, child custody evaluator, mediator, or judge who is a party involved in the ongoing issue. Parents must sign appropriate Release of Information forms, provided by Beljan psychological Services, to initiate this process.

- Beljan Psychological Services reserves the right to close your case and you will be provided three appropriate referral sources for your failure to comply with this policy.

- If any parent/guardian wishes to have Beljan Psychological Services stop services at any given time the request needs to be made directly to Beljan Psychological Services and not to another parent/guardian. _____**(Initials).**

In cases one parent is not able to be present at an appointment I accept the responsibility of communicating with them after every appointment to be updated regarding any change in the treatment plan related to my child's assessment and/or treatment.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.

_____ _____
Printed Name Date

_____
Signature

_____ _____
Printed Name Date

_____
Signature

Paul Beljan, PsyD, ABPdN, ABN
Vanessa Berens, PhD
Kate Haskew, CAGS, NCSP, ABSNP
D. Weaver, PsyD, Post Doctoral Fellow

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IN CASES OF SHARED CUSTODY & SHARED/SOLE FINANCIAL RESPONSIBILITY

I understand that I am responsible for any and all payments due in accordance to the information provided below. For any party responsible for payment a credit card authorization is required for each. Any payments received will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Beljan Psychological Services will take appropriate action. You will be expected to pay for each session at the time it is held. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we reserve the right to use legal means to secure 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.

I _____am responsible for _____% of services rendered

_____ _____
Printed Name Date

_____ _____
Relationship to Child Signature

I _____am responsible for _____% of services rendered

_____ _____
Printed Name Date

_____ _____
Relationship to Child Signature

_____ _____
Administration/Clinician Name Date

_____
Signature

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Credit Card Authorization Form

The purchaser _____ Date: _____
Client/Guardian _____ Date:_____

I _____ hereby authorize Beljan Psychological Services to run the card I am placing on file for services rendered. I understand that these charges will be processed following services rendered and that it is not always immediate _____ (Initials).

In addition, the purchaser should be aware that if they fail to cancel a scheduled appointment at least 24 hours in advance, a no-show fee equal to the price of the session will be charged. _____ (initials)

Please complete all fields.

Credit Card Information
Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐ Other:
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Zip Code (from credit card billing address):
Email:

Purchaser Signature: _____Date: _____

Administration Signature: _____Date: _____