1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Learning Services Quick Intake NEW PATIENT FORMS

Thank you for choosing Sendan Center! Our policies and procedures are all in service of our mission: excellence in child / adolescent mental and behavioral healthcare.

The forms that follow contain important information; please read carefully and initial/sign as indicated. There may be other documents for you to sign at your first appointment.

INFORMATION ALL PATIENTS and CLIENTS NEED TO KNOW

Medical Records
Our medical charts, as in many doctor's offices, are electronic. All information you share with us becomes part of the medical record.

Confidentiality
We place an extremely high value on the confidentiality of our relationship with you.

We need your written permission to release information about you or your care here. There are a very few exceptions to this:

1. To the physician who referred you here – the law allows us to pass on information summarizing our evaluation, diagnosis and recommended treatment. You may ask us NOT to do that, if you wish.
2. We have concern that you are at immediate risk to harm yourself.
3. We have concern that you are at immediate risk to hurt someone else.
4. We have concern that you are not able to take care of your basic needs (such as food and shelter).
5. State law REQUIRES us to report any case of suspected child abuse or neglect.

If there are other individuals or agencies involved in your child's care, we may talk with you about signing a release of information so that all involved parties can communicate efficiently in the interest of providing the best care for your child.

HIPAA Notice of Privacy Practices
Please review this information carefully and save a copy for your records. The HIPAA Notice is available for download on our website and copies are available at the clinic.

Consultations
Sendan Center clinicians regularly participate in external peer professional consultation groups, and also receive consultation with experts in the field. This is a critical means of ensuring the quality of the care we provide. Cases are discussed anonymously.

Sendan Center clinicians also discuss cases internally among relevant and appropriate clinical staff. Cross-disciplinary collaboration is an important part of our work, in the service of excellent care for your child.

Billing and Insurance

Sendan Learning Services are private pay only. We do not bill insurances or Medicaid /HCA. You will receive a rate sheet prior to treatment, and will be billed monthly for services received. Payment is due upon receipt of the bill.

Appointments

Please check in with the receptionist when you arrive. While we try to keep on schedule to avoid keeping you waiting, occasionally we can get behind because of unexpected clinical situations. The receptionist can keep you informed of any delays when you arrive.

If your child is young enough to need supervision while parents are meeting with a clinician at any time, you will need to arrange to have someone watch them.

We do bill for missed appointments and those which were cancelled with less than 48 hours notice.

Telephone Calls

We try our best to return all Front Office calls within one business day and urgent calls sooner. Front Office days of business are Monday through Thursday. You can help us by leaving your phone number and good times to reach you when you leave your message.

Speaking with or consulting with individual clinicians by telephone is subject to clinical availability. If you need to speak with your clinician, it is best to schedule a phone appointment with the front office.

We do bill for telephone calls and letters written on your behalf. These charges are your responsibility.

Email and Text Messaging

Parents sometimes ask to use email and text messaging as a form of communication. Parents should be aware that these forms of communication, though convenient, may not always be technically secure. All efforts will be made to maintain confidentiality via email communication (e.g., only using initials to refer to clients in email communication). Sendan Center Learning Services staff use an encrypted, HIPAA-compliant email service to communicate with parents. Sendan Center policy prohibits the communication of PHI (protected health information) in email. If you are interested in communicating with Learning Services staff via email or text message please complete the Informed Consent signature sheet at the end of this document.

This page deliberately left blank.

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER

excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES
Learning Services QUICK Intake

I acknowledge that I have read Sendan Center Policies and Procedures, and have had the opportunity to ask questions about the information contained there. I acknowledge that knowledge and understanding of my insurance benefits is solely my responsibility.

I will be responsible for payment of uninsured charges, missed appointments, carrying charges, telephone calls and collection charges. I grant permission for this practice to disclose information as legally permissible in the interest of my child's safety and wellbeing.

Please initial each section and sign below to acknowledge you have read, understand and accept the policies described in each section:

_____ Medical Records
Initial

_____ Confidentiality, HIPAA Notice
Initial

_____ Consultation
Initial

_____ Billing and Insurance
Initial

_____ Appointments
Initial

_____ Telephone calls
Initial

_____ Email and Text Message
Initial

Signature Date

Name of patient

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Request and Informed Consent for Use of Email or Text Message to Communicate with Staff at Sendan Center

Client name:

DOB:

Requested email address of parent:

Requested text message number of parent or client:

_____ I will not put protected health information as defined by HIPAA in emails or text messages (please initial)

_____ I will use HIPAA-compliant technology, as identified by Sendan, for file storage and transfer (please initial)

I, the undersigned, certify that I am requesting communication with Sendan Center Learning Services staff via electronic mail (email) and text message. Risk definitely exists that any protected health information contained in such email may be disclosed to, or intercepted by, authorized (e.g. Google in the case of Gmail) and unauthorized third parties. By signing this document, I acknowledge and understand this risk. I also acknowledge and understand that other, more secure methods of communication with Sendan Center staff exist, including communication via telephone or non-electronic written communication. Finally, I acknowledge and understand that Sendan Center staff do not guarantee response to emails within a certain period of time and that all urgent clinical messages must be conveyed to my child's physician, and that in case of emergency I will contact 911 or proceed to the nearest emergency room.

Email communication with Sendan Center Learning Services staff is only for the purposes of scheduling, or routine questions about learning services interventions, not for the communication of urgent or emergent clinical issues.

_____

SIGNATURE / NAME OF CLIENT DATE

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

SENDAN LEARNING SERVICES QUICK INTAKE:

I am seeking (circle one): ASSESSMENT TUTORING / TREATMENT BOTH

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

Grade (as of Fall 20__): _____ School: _____

Current teacher(s): _____ Any grades repeated: _____

Parents' Name(s): _____

Address: _____ _____

Phone number (home, work, cell): _____

_____ _____

Party responsible for payment: _____ Employer: _____

Who referred you to Sendan Center?

Pediatrician / Physician:_____ Teacher / School:_____

Friend Other:_____

What are the issues that you are concerned about? (Please give as much detail as possible.)

1._____

_____

_____

_____

_____

2._____

_____

_____

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

3.

What kind of help do you feel your child / family needs?

1.

2.

3.

What kind of help does your child say he/she needs?

1.

2._____

_____

_____

_____

_____

3._____

_____

_____

_____

_____

Has your child had any learning-disability related testing done before?

What kind of tests: _____

Where / by whom: _____

Dates: _____

Diagnosis / Diagnoses: _____

Please provide copies of test results and/or reports.

Does your child have an IEP or 504 Plan at school?

Please provide a copy of the school's most recent evaluation report and the current IEP or 504 Plan.

If your child is receiving services at school, what have you found most helpful and/or most challenging? _____

_____

_____

_____

_____

_____

What does your child most enjoy about school?

_____

_____

_____

_____

What do you see as your child's primary learning strengths?

_____

_____

_____

_____

What areas do you see as your child's primary learning challenges?

_____

_____

_____

_____

Has your child received any academic tutoring outside of school?

Where / by whom: _____

Dates: _____

What helped? _____

What didn't help? _____

Educational History

Have teachers expressed concerns about your child's skills or performance in school? If so, please begin with the grade your child was in when concerns first emerged and briefly note what teachers each year since then have expressed (For older students, you may choose to summarize only the initial concerns and the most recent 2-3 years)

_____

_____

_____

_____

_____

Have you agreed or disagreed with the concerns that teachers or other have expressed? (If disagree, please explain.)

_____

_____

Developmental History

History of developmental difficulties or delays in talking / walking / playing /social skills / attention skills / behavior / other (If yes, please comment): _____

_____

_____

_____

Medical History

Within the past 12 months, at school or at the doctor's office, my child has had a:

Hearing Test YES NO DON'T KNOW Any concerns identified?_____

Vision Test YES NO DON'T KNOW Any concerns identified?_____

Please provide copies of test results and/or reports, if applicable.

History of head injury / epilepsy / surgery / illness / hospitalization (If yes, please comment):

_____

_____

_____

_____

Does your child take any medications?

Medication: _____

Prescribed by: _____ Dose: _____

Reason: _____

Psychiatric / Psychological History

History of anxiety / depression / ADHD / other (If yes, please comment): _____

_____

_____

_____

Diagnosed by:_____ Date of diagnosis:_____

Treatment (e.g., medication, psychotherapy) :_____

Dates:_____ Was treatment helpful? _____

Family History

Any known family history of problems with speech / hearing / learning / attention / social skills (If yes, please comment): _____

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO GIVE US THIS VALUABLE INFORMATION.

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Receipt of Sendan HIPAA Notice of Privacy Practices

The Sendan Center HIPAA Notice of Privacy Practices describes in detail your rights and our responsibilities regarding how your health information may be used and disclosed, and how you can access your information.

It is available on our website and in hard copy at our office.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Printed name of patient

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient

Relationship (Parent, legal guardian, personal representative)

This form will be retained in the patient's medical record.

(Effective September 23, 2013)