

Sendan 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 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 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.

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 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.

BILLING AND INSURANCE

Billing and Payment Procedures depend on the service you are receiving. We know this information is complicated. We are always here to answer your questions.

In General:

Most insurances have an amount that is due at the time that services are delivered. These co-payments are due at the time of service. We accept cash, personal checks, Visa and MasterCard in payment.

If there is still a balance after we bill your insurance, we will bill you for that amount. These amounts are set by your insurance company, and may be due to a deductible or a combination of copayment (the amount you pay at the time of service) and/or a coinsurance amount.

You are responsible for understanding how your insurance works. We will try to be helpful with understanding those issues. You are also responsible for any amounts that your insurance will not pay for. If you change insurance providers without notifying us, we may not be able to retroactively bill the correct insurance – in that case you are responsible for paying for the treatment you received.

We charge a \$5.00 fee on accounts with a patient-responsible balance owing where a payment was not made during the month.

We may charge a fee for documents requested by outside parties. These include, but are not limited to, preauthorization for medications (requested by your insurance company), disability forms (requested by the State), medication forms (requested by schools or camps). During treatment, you may ask for letters to be written, conferences with schools or outside agencies, or telephone consultations. Insurances typically do not pay for these types of services. If we charge, you will be personally responsible for these charges. We do not charge for authorized exchange of information between Sendan Center and other providers, such as your physician or another therapist.

Let us know immediately if you expect to have trouble paying your bill.

If you have an insurance that we do not bill, you may wish to check to see if you have “out of network” coverage. If you do, you may be able to bill your insurance company yourself and receive partial reimbursement. We can provide you with the information necessary to do that billing on your own. You will need to pay in full for services at the time of service, and then be given a statement you can submit to your insurance company for reimbursement.

We reserve the right to submit unpaid bills to a collection agency. In some cases this may result in legal action, which the collection agency will initiate.

Mental health billing can, unfortunately, be extremely complicated, and there are multiple points in the billing process where someone (patient, insurance company, provider) can make an error. In our experience, billing and payment conflicts often arise when families disregard the policies and procedures described in this document. However, sometimes billing and payment conflicts occur despite everyone’s best efforts. Our staff are dedicated to approaching billing and payment issues from a problem-solving perspective, with patience and goodwill.

Payment is always due at the time of service. If the receptionist is not available, you may leave a check or cash with your therapist. Alternatively, you may send us your credit card number on your billing statement or pay over the phone.

If your minor or dependent child is unaccompanied to their appointment, arrangements should be made for payment of any charges due on the day your child is seen. For example, we can accept credit card payments over the phone if you do not wish to send payment with your child.

Sendan Center is only a preferred provider with Regence (and HMA, which uses Regence providers), Premera (and Lifewise, which is a part of Premera), and Kaiser Permanente. If you provide us with complete and accurate information, we will bill those insurance companies for you. When you have insurance changes, please be sure to let us know about them. We do not bill any other third-party payers or insurance companies. If you have any other insurances than those listed above, you are responsible for the bill at the time of service.

Sendan Autism Services*

Sendan Autism Services is contracted with the insurance companies listed above. Some of our providers also accept Molina and HCA Fee-For-Service for autism diagnosis evaluations and treatment (such as speech-language-communication therapy specific to an autism diagnosis). The front office can give you an estimate for diagnosis and/or treatment costs depending on the unique needs of your child, and the providers involved, and will guide you through the steps necessary for us to be able to bill your insurance.

Sendan ABA Services*

Sendan ABA Services is contracted with the insurance companies listed above, as well as Molina, DDA and HCA Fee-For-Service. Each payor has a different process they will want you to go through before they will reimburse for ABA services. The front office can give you a rate sheet for all services and guide you through the steps necessary for us to be able to bill your insurance.

Sendan Learning Services*

Some Sendan Learning Services are billable to insurance, and others are not:

Language disorder assessment and therapy, tutoring and executive function coaching: Private pay only. We do not bill insurances, Molina, or HCA for these services. 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.

* We recognize how incredibly confusing it is to understand what services are and are not covered by which insurances. Insurances have a lot of rules that providers and patients must follow. Please contact us with your questions, and we will work together with you to figure out if we can bill your insurance for the services your child needs.

Appointment Policies

All Sendan Center Service programs will require the initial paperwork. Please bring completed forms to your first appointment or mail, fax or drop off prior to your appointment.

We charge you for missed appointments and visits cancelled with less than 48 hours' notice. Insurance will not reimburse for missed appointments; you are responsible for those charges at the full cost of the appointment.

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.

Medication Refills

If you need a prescription refill, first contact your pharmacy. They will fax our office asking for a refill. We require 48 hours advance notice for such a request, and 72 hours' notice on Fridays.

If there are no refill authorizations on your current prescription, you will need to be seen by your prescriber to renew the prescription. Please be sure you have scheduled an appointment with your prescriber well in advance of the prescription running out.

Stimulants and other medications may require handwritten prescriptions. If you do not have a prescription to fill, you may need an appointment with your prescriber. Please be sure to schedule an appointment before you run out. Federal Law requires that patients on stimulants be seen every three months. Lack of timely appointments or notification of refill requests may lead to you not being prescribed your medications. Your safety and wellbeing are our chief priority.

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 Friday. 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, including those required to ensure prescribed medications are covered by your insurance. However, insurances do not typically pay for phone calls and writing letters. These charges are your responsibility.

Coverage

At times we will be unavailable for urgent/emergent needs and will arrange coverage for these periods with other professionals, as appropriate.

Emergencies

If you have an emergency, please call 911 or go to the emergency room nearest you. We are not able to safely handle emergencies during office hours, as we are providing patient care.

For urgent concerns (which are not emergent), you may leave a message and we will attempt to get back to you within one business day.

For non-emergent but clinically urgent issues after regular business hours, please call the main number and follow the after-hours paging instructions.

This page is deliberately left blank.

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

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 to my insurer as necessary to process my claims, and as legally permissible in the interest of my 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 _____ Policies and Guidelines
 Initial _____ Appointments
 Initial _____ Medication Refills
 Initial _____ Telephone calls
 Initial _____ Coverage
 Initial _____ Emergencies
 Initial _____

Signature _____ Printed name _____ Relation to Patient _____ Date _____

Name of Patient _____ Date of birth _____

YOUR BILLING INFORMATION

Please check one:

- Regence (including HMA)
- Premera (including Lifewise)
- Kaiser Permanente
- Molina: for some services only; please see details under Billing and Insurance Policies above
- HCA Fee-For-Service: for some services only; please see details under Billing and Insurance Policies above
- DDA (Developmental Disabilities Administration): for some services only; please see details under Billing and Insurance Policies above

(Other insurances are not billed)

Insurance ID# _____
 Group Number _____
 Name of Insured _____
 Name of Guarantor _____ Guarantor's Date of Birth: _____
 Guarantor's address: _____ City: _____
 State: _____ Zip code: _____
 Guarantor's best contact phone number: _____

Have you checked on your benefits with your insurance company? Yes No

(We strongly suggest that you do check this to be sure that you understand if you have any deductibles, what your copayment or coinsure amounts might be, whether the services you will be receiving are covered, and how many visits you may have available to you.)

Kaiser insurance requires preauthorization for all services. For Psychiatry and Psychotherapy services, please call the member services number on the back of your insurance card. For other services, please ask your child's primary care physician (PCP) to submit a referral. If you or your child's PCP need any information (such as provider names or billing codes) in order to submit that referral, we can provide that information.

Without that preauthorization, we cannot bill Kaiser for services.

Other insurances sometimes require referral and/or preauthorization for some services. In these cases we will let you know before your first visit what additional steps are required by your insurance company.

NAME OF PATIENT

PATIENT'S DATE OF BIRTH

(PLEASE KEEP IN MIND THAT MANY OF THESE ARE EITHER STANDARD OR REQUIRED QUESTIONS; NOT ALL WILL APPLY TO YOU)

SENDAN CENTER INTAKE AND CONSENT FORM

Seeking (please circle): Diagnosis Treatment Both Not sure

This intake paperwork is for:

Sendan Psychiatry / Psychotherapy
 Sendan Autism Services

Sendan ABA Services
 Sendan Learning Services

LGBTQIA+ Services
 Not Sure

Is the individual under department of corrections (DOC) supervision? Yes No

Is the individual under civil or criminal court ordered mental health or substance use disorder treatment? Yes No

Is there a court order exempting the individual participant from reporting requirements? Yes No If 'Yes', a copy of the court order must be provided.

IDENTIFYING INFORMATION:

Name: _____ Date of Birth: _____

Ethnicity/race: _____ Primary Language: _____

Gender Identity: _____ Sex assigned at birth: _____ Pronouns: _____

Preferred Name: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Years of education/degree: _____

Occupation: _____

Emergency Contact:

Emergency contact: _____ Relationship: _____

Family Members:

Please list all people currently living in your primary home:

NAME	GENDER	AGE	RELATIONSHIP

Please list other adults or children significant to you who do not reside in the household:

Have you moved in the past 12 months? Yes No

Have you experienced homelessness in the past 12 months? Yes No

Is your current housing adequate to meet your needs? Yes No

Please indicate any major stresses you are currently experiencing or have experienced within the last year:

- marital discord/fighting
- birth/adoption of a child
- custody disagreement
- abandonment by parent
- divorce
- loss of loved one
- financial problems
- physical abuse
- other: _____
- parent/sibling death
- parent emotionally/physically ill
- parent substance abuse
- legal issues
- sexual abuse

Do you have any family members in the area that you can rely on for help? Yes No

Do you have any friends in the area that you can rely on for help? Yes No

Do you have any other adults in the area that you can rely on for help? Yes No

REASONS FOR EVALUATION

Who referred you to Sendan Center? _____

What are your concerns? Please provide as much detail as possible, including the nature of any symptoms or behaviors, onset, duration, frequency and severity: _____

Did a specific event lead to this request for evaluation/treatment? Yes No. If so, please describe:

What do you hope will come out of this evaluation/treatment?

HEALTH HISTORY

Who is your primary doctor? _____ Phone #: _____

Address: _____

When were you last seen by a medical professional? _____

For what reason? _____

Date and results of last physical examination: _____

Current height: _____ weight: _____ BMI: _____

Is your general physical health good? Yes No

Serious and / or chronic illness now (or in past)? _____

Any sleep problems? _____

Typical range of times when you fall asleep: _____

Typical range of times when you wake up: _____

Do you snore, gag or ever appear to stop breathing during sleep? _____

Do you have any of these in the bedroom: computer television monitor for video games

How do you wind down at the end of the day? _____

Are immunizations up to date? Yes No

Do you have any of the following impairments/conditions (documented)? none reported unknown developmental disability visual disability deaf hard of hearing medical/physical disability neurological disability fetal alcohol syndrome or effects

If yes, please provide details _____

Have you had any history of seizures/convulsions (including with exercise, startle, or fright) or head injury/concussion? yes no

If yes, please provide details _____

Have you fainted, blacked out, or experienced episodes with loss of consciousness? yes no

If yes, please provide details _____

History of medical hospitalizations and/or surgeries: None Unknown

Doctor or Hospital	Dates/duration:	Conditions treated:	Complications:	Discharge status:

Current ongoing use of non-psychotropic medications for physical health: None Unknown

Name of medications:	Conditions:	Prescribing MD:	Dose/Schedule:	Purpose	Response/Side Effects:

Use of vitamins, herbs, supplements, homeopathy, or naturopathic remedies? None Unknown

Current	Past	Name of treatment:	Conditions:	Prescribing MD:	Purpose	Response/side effects:

Have you had any of the following? (please give details):

recurrent headaches

recurrent stomach aches, nausea

recurrent diarrhea

recurrent vomiting

constipation or soiling

vision problems

hearing problems

ear infections

recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia)

ALLERGIES (INCLUDING MEDICATION)

wheezing or asthma

problems with urination, including wetting

weight loss or gain

skin problems _____

problems with bones, muscles or joints

tremor, shakes or jitters

unusual movements, including tics or twitches

shortness of breath with exercise (more than others of the same age) in the absence of an alternative explanation (e.g. asthma, sedentary lifestyle, obesity)

poor exercise tolerance (in comparison with others) in the absence of an alternative explanation such as asthma, sedentary lifestyle, or obesity _____

palpitations brought on by exercise

Do you have any pain issues or concerns? Yes No If yes, explain: _____

Sexual Development IF APPLICABLE (menstruation history, sexual activity, use of contraception, pregnancy history): _____

FAMILY HEALTH HISTORY:

Does anyone in your family have any of the following conditions?

Check all that apply, past or present:

Condition/Circumstance	Patient	Mother	Father	Sibling(s)	Mother's Family	Father's Family
Pathological Gambling						
Suicide or Suicide Attempts						
Harm to Self: Cutting						
Harm to Self: Anorexia / Bulimia						
Violence / Harm to Others						
Birth Defect						
Cerebral Palsy						
Intellectual Disability						

Chromosomal / Genetic disorder						
Tuberous Sclerosis						
Epilepsy / Convulsions						
Severe Head Injury						
Migraine Headaches						
Alzheimer's Disease						
Parkinson's Disease						
Autism / Aspergers / PDD						
ADD or ADHD						
Learning Disorder						
Speech/Language Delay						
Motor Skills Difficulties						
Schizophrenia						
Alcohol Abuse						
Drug Abuse						
Physical Abuse						

Condition/Circumstance	Patient	Mother	Father	Sibling(s)	Mother's Family	Father's Family
Sexual Abuse						
Emotional Abuse						
Depression						
Mania / Bipolar Disorder						
Nervousness / Anxiety						
Panic Attacks						
Obsessive Compulsive Disorder						
Psychiatric Hospitalization						
Deaf/ Hard of Hearing						
Tics or Tourette Syndrome						
Special education						
School suspension / expulsion						
Harassment by peers						
Juvenile Delinquency						

Arrests/Incarceration						
Homelessness						
Teen Pregnancy						
Cancer						
High Blood Pressure						
Heart Disease						
Stroke						
Hemophilia						
Kidney Disease						
Diabetes						
Multiple Sclerosis						
Sickle Cell Anemia						
Muscular Dystrophy						
Physical Handicap						
Food Allergy						

If there any known family history of the following heart problems: Long QT Syndrome, abnormal heart rhythm problems, Wolff-Parkinson-White syndrome, cardiomyopathy, heart transplant, pulmonary hypertension, unexplained motor vehicle collisions or drowning, or implanted defibrillator? Yes No Unknown

If yes, explain: _____

Please describe mother's childhood: _____

Please describe father's childhood: _____

PSYCHOLOGICAL HISTORY

How is your overall emotional health? _____

Have you had any history of the following emotional/behavioral problems:

specific phobias/fears:

self-harm:

History of violence/grief and loss:

Have you been exposed to violence or fighting between parents? Yes No

Have you been a witness to violence or traumatic death? Yes No

Have you experienced death of parent/psychological parent/sibling? Yes No

Child abuse/neglect history: Not applicable

History of physical abuse sexual abuse persistent inadequate parenting or neglect?

If applicable, has abuse/neglect been documented by CPS/legal system? yes no

Has the abuse history been previously addressed by a professional? yes no If so, how?

List all current and past outpatient psychiatric/psychological/mental health services utilized: None Unknown

Provider Name(s):	Dates of Contact:	Services Provided:	Outcomes:	Termination Reason(s):

List any history of psychiatric hospitalization and/or residential treatment: None Unknown

Facility Name(s)	Dates of Contact:	Services Provided:	Outcomes:	Discharge Status:

List any use of psychotropic/psychiatric medicines: None Unknown

Current	Past	Name of medications:	Conditions:	Prescribing MD:	Dose/schedule:	Response/side effects:

Please list all other persons or agencies who have evaluated you in the past:

Type of Service	Service Provider/address:	Results:	Dates:

SOCIAL HISTORY

Check the phrases that describe you:

- Overly quiet
 Overly active
 Destructive
 Very shy
 Perfectionistic
 Friendly/outgoing

Do you have any past or current substance use/abuse? cigarettes e-cigarettes drugs alcohol marijuana none
 If yes, please describe substances used, amount, and effect: _____

Please make a brief statement about the relationship between you and

Mother/maternal caregiver: _____

Father/paternal caregiver: _____

Siblings: _____

The closest relationship is between you and _____

Please list your qualities that you consider to be strong positive points/areas of strength:

Please list your qualities that you consider to be the most difficult or challenging.

Please tell us about your family's strong positive points / areas of strength:

EDUCATIONAL AND VOCATIONAL HISTORY

Are you currently enrolled in school? yes no

Current school:

School Name: _____

Grade: _____

Years completed: _____

Area of study: _____

CULTURAL HISTORY

Please answer these questions only if you feel the answers are helpful to our understanding of you and your family:

Ethnic/cultural identification: _____

Language spoken at home: _____

Religious/spiritual practices of self/caregivers/family: _____

Culturally/socially relevant beliefs regarding mental health and illness (include beliefs about the current problem, general beliefs about illness, health and treatment):

Is there anything else you would like us to know that we did not ask?

By my signature below I consent to receiving mental and behavioral health (and related services, as appropriate, e.g. speech language or learning services) assessment, evaluation and/or treatment at Sendan Center.

Printed name of patient

Signature

Date

Printed name if signed on behalf of the patient

Relationship (Parent, legal guardian, personal representative)

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)