

Learning Services 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 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

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.

Late Cancellations and Missed Appointments

We will charge you for missed appointments and visits cancelled with less than 48 hours' notice. You will be billed for 50% of appointment cost.

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.

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 or text 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

SENDAN CENTER

*excellence in child & adolescent
mental and behavioral health*



4201 Meridian Street, Suite 113

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p 360.305.3275

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communicating with Learning Services staff via email or text message, please complete the Informed Consent signature sheet at the end of the document.

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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	
_____	Appointments
Initial	
_____	Telephone calls
Initial	
_____	Email and Text Message
Initial	

Signature	Printed name	Relation to Patient	Date
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Name of Patient	Date of birth
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Informed Consent for Requesting Email or Text Message Communication With Learning Services

Patient name:

DOB:

Requested email address:

Requested phone number(s):

- I will not put protected health information as defined by HIPAA in emails or text message.
- I will use HIPAA compliant tech. for file storage and transfer as identified by Sendan.

I, the undersigned, certify that I am requesting communication with Sendan Center staff via electronic mail (email) and/or text. 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 that other, more secure methods of communication with Sendan Center staff exist, including communication via telephone, fax, or non-electronic written communication. Finally, I acknowledge and understand that Sendan Center staff does not guarantee response within a certain period of time and that **any urgent or emergent needs must be communicated via telephone.**

Sendan Center staff will use the minimum necessary amount of protected health information to respond to your query.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE



SENDAN LEARNING SERVICES 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 grade repeated: _____

Parent's 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).

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



What kind of help does your child say they need?

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 a 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 enjoy most 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 express (For older students, you may choose to summarize on the initial concerns and the most recent 2-3 years)

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



Communication History

History of speech-language delay / hearing issues / fluency or voice issues / word finding difficulty / difficulty understanding what is said or read / difficulty retelling or expressing information when speaking or writing / difficulty with humor, figurative language, and/or implied meaning (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 medication?

Medication: _____

Prescribed by: _____ Dose _____

Reason: _____



Psychiatric / Psychological History

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

Diagnosed by: _____ Was treatment helpful? _____

Family History

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

CONSENT FOR TREATMENT

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)