SENDAN CENTER
excellence in child & adolescent mental and behavioral health

4201 Meridian Street, Suite 113
Bellingham, WA 98226
www.SendanCenter.com
p 360.305.3275
f 360.734.5503

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 at Sendan Center.
The **exceptions** to this rule are:

1. To the physician who referred you here – state 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 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. If we suspect child abuse or neglect, we are REQUIRED to report this by state law.

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.

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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.

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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.

Sendan Psychiatry and Psychotherapy

Payment is always due at the time of service. 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).

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.

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.

Speech-Language Therapy: Regence, Premera, Kaiser, and Molina

* 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 you need.

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APPOINTMENT POLICIES

We charge you for missed appointments and visits cancelled with less than **48 hours (2 business days)** 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.
If receiving mental health services via telehealth, please log into HIPAA-compliant website Doxy.me for tele-health. You can find links to all psychiatry and psychotherapy clinicians on our website, by clicking on "COVID-19 FAQs" and scrolling to the bottom. While we try to keep on schedule to avoid keeping you waiting, occasionally we can get behind because of unexpected clinical situations or technology issues. If you are waiting longer than 10 minutes in the Doxy.me waiting room, please call Sendan Center at (360) 305-3275 to check on status updates.
Please make sure that if you are engaging in telehealth, you have headphones and a private location to support confidentiality and privacy laws.

Medication refills

If you need a prescription refill, first contact your pharmacy. They will contact our office asking for a refill. We require 48 hours (2 business days) advance notice for such a request.
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 well in advance of the prescription running out.
Stimulants and other medications may require specially mediated or handwritten prescriptions. If you do not have a prescription to fill, you may need an appointment. Please be sure to schedule an appointment before you run out. Federal Law requires that patients on stimulant medications (e.g. methylphenidate, Ritalin, Concerta, Adderall, mixed amphetamine salts, Vyvanse, dexmethylphenidate, Focalin) be seen every three months. Lack of timely appointments or notification of refill requests may lead to you not being prescribed their medications. Your safety and wellbeing are our chief priority.

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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.

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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

_____ 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

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YOUR BILLING INFORMATION

Please check one:

- o Regence (including HMA)
- o Premera (including Lifewise)
- o Kaiser Permanente
- o Molina: for some services only; please see details under Billing and Insurance Policies above
- o HCA Fee-For-Service: for some services only; please see details under Billing and Insurance Policies above
- o 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? o Yes o 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 primary care physician (PCP) to submit a referral. If your PCP needs 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.

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(*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 ABA Services ☐ LGBTQIA+ Services
☐ Sendan Autism Services ☐ Sendan Learning 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:

Name: _____ Phone #:_____
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

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

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

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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:

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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): _____

_____

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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						

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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						

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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):

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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:

_____
_____
_____

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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?

_____
_____
_____
_____
_____
_____
_____

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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.

Patient Printed Name	Date	Time
Patient signature	Date	Time
Parent or legally authorized individual signature	Date	Time
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.

Patient Printed Name	Date	Time
Patient signature	Date	Time
Parent or legally authorized individual signature	Date	Time
Printed name if signed on behalf of the patient	Relationship (Parent, legal guardian, personal representative)	

TO BE SIGNED BY THE EVALUATING CLINICAL STAFF:

I hereby acknowledge that I have read and reviewed the Sendan Center New Patient forms and Family-submitted Intake Questionnaire:

Clinical Staff signature	Date

This form will be retained in the patient's medical record.
(Effective September 23, 2013)