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

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.

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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 of 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 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 Date

Printed name Relation to Patient

Name of Patient Patient's Date of birth

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Informed Consent for using email or text message to communicate with staff at Sendan Center

Patient name: _____ Date of Birth:_____

Requested email address:_____

Who does this email belong to?: _____

Requested phone number(s): _____

Who does this phone number belong to?: _____

Sendan:

- Will not put protected health information as defined by HIPAA in emails or text message.
- 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

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SENDAN LEARNING SERVICES INTAKE

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

Client's Name: _____ Date of Birth:_____ Age_____

Preferred name (if different from above): _____ Pronouns: _____

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

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

Parent Name(s)_____

Address: _____

Phone Number (Home, Work, Cell):_____

Who does this number belong to?_____ Ok to leave detailed message? Y / N

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 the child/your family needs?

_____

_____

_____

_____

_____

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What kind of help does the client say they need?

_____

_____

_____

_____

_____

Has the client had any learning disability-related testing done before? ☐ **Yes** ☐ **No**

If yes:

What kind of tests: _____

Where/by whom:_____

Dates:_____

Diagnosis/Diagnoses:_____

Please provide copies of test results and/or reports.

Does the client have an IEP or a 504 Plan at school? ☐ **Yes** ☐ **No**

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

If the client is receiving services at school, what have you found most helpful and/or most challenging?

_____

_____

_____

_____

_____

What does the client enjoy most about school?

_____

_____

_____

_____

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What do you see as the client's primary learning strengths?

_____

_____

_____

What areas do you see as the client's primary learning challenges?

_____

_____

_____

Has the client received any academic tutoring outside of school? ☐ Yes ☐ No

If yes:

Where/by whom:_____

Dates: _____

What helped? _____

What didn't help?_____

Educational History

Have teachers expressed concerns about the client's skills or performance in school? If so, please begin with the grade the client 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).

_____

_____

_____

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Medical History

Within the past 12 months, at school or at the doctor's office, has the client 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 the client take any medication? ☐ Yes (please list below) ☐ No

Name of medication:	Prescribed by:	Dose/Schedule:	Purpose:

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):

_____

_____

_____

_____

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Consent for Treatment

By my signature below I consent to this client 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

Patient signature (if 13 years of age or older) 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

Patient signature (if 13 years of age or older) 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)