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. If a client is 13 years old or over, we need that client to give written permission.

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 or 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 you or 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.

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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 for your child.

TEENS AND PRIVACY RIGHTS

Teens have privacy rights for some health issues. To provide the best care and comply with state laws, we may ask to talk with your teen in private. The laws are about:

- Giving consent for care or treatment
- Privacy issues about confidential services for drug and alcohol abuse and mental health

As teens grow, so does their need for privacy and independence. We are committed to giving your teen the best care. We are able to do this by talking with them in private. We know there are times when teens will not tell us important information about their health if we do not give them a place to talk in private and keep their information private from their parents.

Involving parents in care

We are family-centered and strive to involve the parent or guardian in the care and well-being of their child. We encourage teens to talk with their parents or guardians about serious issues and will offer to help start the conversation if they would like that help.

Mental health

A teen who is 13 years old or older may give consent for outpatient care and treatment for mental health concerns. Consent from a parent or guardian is not required.

If a teen needs psychiatric treatment and refuses to consent for care, a parent, legal guardian or other adult caregiver may consent for outpatient care under Family-Initiated Treatment law.

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.

Sendan ABA Services is contracted with Regence (including Uniform and HMA, which use Regence providers), Premera (and Lifewise, which is a part of Premera), Kaiser Permanente, 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.

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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.

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.

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APPOINTMENT POLICIES

Initial Evaluations for Sendan Autism Services, Sendan ABA Services and Sendan Learning Services will vary depending on the needs of the child and family.

If the client is receiving services from more than one department at Sendan Center, please note that policies around late cancellations, missed appointments, and communication are different for our ABA providers than for our Psychiatry and Psychotherapy or Learning Services providers.

Please refer to the cancellation policies listed in the ABA Parent Manual for detailed information about how we manage and bill for missed appointments or late cancellations for ABA.

Please make sure that if you are engaging in telehealth, you have headphones and a private location to support confidentiality and privacy laws.

OTHER POLICIES:

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 the 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

_____ Teens and Privacy Rights
Initial

_____ Billing and Insurance
Initial

_____ Appointment Policies
Initial

_____ Telephone calls
Initial

_____ Coverage
Initial

_____ Emergencies
Initial

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)	

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SENDAN CENTER ABA INTAKE AND CONSENT FORM

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

Please enter the following information for the child for whom you are seeking services:

Child's name: _____ Date of Birth: _____
Preferred name(s) if different from above:_____
Current gender identity: _____ Sex assigned at birth:_____
Pronouns (*how should we refer to the child when not using their full name?*): _____
Ethnicity/race: _____ Primary Language:_____
Primary address: _____
_____

Who should we contact for scheduling and intake questions?

Name:_____ Relationship to client: _____

Primary phone number: _____ Email: _____
Ok to leave detailed message? ☐ Y ☐ N

Who is the child's primary health care doctor? _____

Organization/practice name (*ex. PeaceHealth Pediatrics*): _____

Phone number: _____

DIAGNOSIS INFORMATION:

Many insurance companies are more likely to authorize ABA therapy for children with an autism diagnosis, and in most cases they will require a copy of the evaluation report or doctor's notes from when the child was diagnosed. An autism diagnosis is not required for ABA therapy, but please list any other mental, behavioral, or developmental diagnoses the child has received.

Has the child received an autism diagnosis?

☐ Yes, the child **has** an autism diagnosis:
Who diagnosed the child? _____ Date of diagnosis: _____
Do you have access to a copy of the evaluation report or visit notes from when the child was diagnosed? ☐ Yes ☐ No
If you have a copy of the evaluation report showing the child's diagnosis, please provide a copy

☐ No, the child **does not** have an autism diagnosis, and:
☐ has an appointment for autism evaluation: Provider: _____ Date: _____
☐ is on a wait list for autism evaluation (where?): _____
☐ does not have an evaluation scheduled and is not on any waitlists for evaluation

Does the child have any other diagnoses relevant to behavioral health treatment? If so, please list here:

Diagnosis	Provider who diagnosed:	Date of Evaluation:

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YOUR BILLING INFORMATION

Primary Insurance - Please check one:

- ☐ Regence (including HMA and Uniform)
- ☐ Premera (including Lifewise)
- ☐ Other Blue Cross Blue Shield plan
- ☐ Kaiser Permanente
- ☐ Aetna
- ☐ Molina
- ☐ Not listed above (paying out of pocket)

We are not able to bill other insurances

Insurance ID Number: _____

Group Number (if shown on card): _____

Name of Insured (the child) **as listed on insurance**:_____

Name of Subscriber (the policy holder):_____

Subscriber's Date of Birth:_____ Subscriber's gender (as listed with insurance):_____

Subscriber's Address*: Street:*_____

City:_____ *State*:_____ *Zip code*:_____

Subscriber's best contact phone number:_____

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

We strongly suggest that you contact your insurance 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.

If the patient has secondary insurance, please list below:

Secondary Insurance:

- ☐ Regence (including HMA and Uniform)
- ☐ Premera (including Lifewise)
- ☐ Other Blue Cross Blue Shield plan
- ☐ Kaiser Permanente
- ☐ Aetna
- ☐ Molina

Secondary Insurance ID Number: _____

Group Number (if shown on card): _____

Name of Subscriber (the policy holder):_____

Most insurances will require referral and/or preauthorization for ABA services. In these cases, we will let you know before your first visit what additional steps are required by your insurance company and may request additional documents from you or from the client's primary care physician before we are able to start providing services.

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PARENT/CAREGIVER INFORMATION:

Who has current custody/guardianship of the child?

☐ Both parents (same household)
☐ Both parents (separate households)
☐ One parent/guardian: _____
☐ Relative: _____
☐ Other: _____

Is there a court-ordered parenting plan in place for custody of the child? ☐ Yes ☐ No

If yes, who has medical decision-making authority for the child? _____

If a parenting plan exists, please provide a copy.

Information about Parent/Caregiver 1: ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____ Date of Birth: _____ Gender: _____
Address: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N
Email address: _____
Marital status: _____ Years of education/degree: _____
Occupation: _____ General health: _____

Information about Parent/Caregiver 2 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____ Date of Birth: _____ Gender: _____
Address: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N
Email address: _____
Marital status: _____ Years of education/degree: _____
Occupation: _____ General health: _____

Information about Parent/Caregiver 3 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____ Date of Birth: _____ Gender: _____
Address: _____

Information about Parent/Caregiver 4 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____ Date of Birth: _____ Gender: _____
Address: _____

Emergency Contact (if someone other than parent/caregiver):

Emergency contact name: _____ Phone Number: _____
Relationship: _____

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Please list all people currently living in the child's primary home:

NAME	RELATIONSHIP	AGE	GENDER

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

_____

_____

_____

ABA SERVICES REQUEST:

Did you receive a medical referral for ABA therapy? ☐ Yes ☐ No

(If yes) Name of referring provider: _____ Practice/Organization:_____

Has the child's doctor provided a prescription letter or order for ABA services? ☐ Yes ☐ No

If **yes**, please provide a copy.

If **no**, please consider requesting a prescription letter for ABA from the child's primary care physician. Most insurance companies will require this before agreeing to pay for ABA services.

What is your availability for ABA appointments? (check all that are possible)

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings, during school hours	☐	☐	☐	☐	☐
Afternoons, during school hours	☐	☐	☐	☐	☐
Evenings, after school hours	☐	☐	☐	☐	☐

Where would you prefer for the child to receive ABA services? (check any that apply)

☐ At home ☐ At Sendan Center's clinic ☐ At school ☐ No preference/not sure

We are currently only able to provide in-home ABA services to clients located within our service area, which we define as 20 minutes or less by car from our clinic in Bellingham (4201 Meridian St, Bellingham, WA 98226).

Does the client live within a 20-minute drive from Sendan Center? ☐ Yes ☐ No ☐ I'm not sure

If the child lives outside of our service area, would you be able to commit to bringing them to our clinic for at least 3 sessions per week? ☐ Yes ☐ No ☐ I'm not sure

What do you want ABA to help the child and family with? _____

_____

_____

_____

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Please describe any behavior issues your child has (ex: self-injurious, aggressive towards others, etc.): _____

_____

_____

_____

_____

What methods have been used to try to decrease behaviors? How effective have these methods been? _____

_____

_____

Please describe the child's current communication skills (ex: sign language, PECS, verbal): _____

_____

Does the child have any favorite games, hobbies, or interests? _____

_____

If your family has cultural, religious, ethnic, or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family, please describe below: _____

_____

_____

Is there anything else you would like us to know about the child or your family? _____

_____

_____

_____

CHILD & FAMILY HEALTH HISTORY

Was the child born: ☐ On time ☐ Early ☐ Late ☐ I'm not sure

If there were any complications with the child's birth, please describe: _____

_____

Did you have any concerns about the child's development? ☐ Yes ☐ No ☐ I'm not sure

If yes, please describe: What were your concerns? When did you first start to notice them? _____

_____

_____

Is the child currently taking any medications? ☐ Yes (please list below) ☐ No

Name of medication:	Dosage:	When given:	Used to treat:	Prescribed by:

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Does the child have any medical conditions or allergies that need to be considered when delivering ABA treatment? If so, please give details: _____

_____

_____

Is there any history of mental or behavioral health issues in the child's immediate or extended family? If so, please list below:

Relative (mother, sibling, uncle, etc.)	**Condition(s)**	**Details (optional)**

CURRENT & PREVIOUS SERVICES

School Information:

Is the child currently enrolled in school? ☐ Yes ☐ No ☐ Not now, but was in the past

If child is or was enrolled in school, please fill out information below:

School placement: ☐ Current ☐ Past

School Name: _____ Grade: _____School District: _____

Phone #: _____Teacher/Counselor/IEP Coordinator: _____

Any grades repeated? _____

Is the child enrolled in special education? ☐ yes ☐ no

Child is designated: ☐ Seriously behaviorally disordered ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room ☐ Self-contained classroom
☐ Generic special education classroom ☐ Inclusion in regular education (_____ hours/day)
☐ Other: _____

How is the child currently functioning at school? _____

_____

_____

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

_____

_____

_____

Does the child have an IEP or 504 Plan at school? ☐ Yes ☐ No ☐ In Progress

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

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Has the child ever received behavioral services (including ABA or EIBI) before? ☐ Yes ☐ No ☐ I'm not sure

If the child receives or has received behavioral services, please complete below:

Behavioral Consultation Provider Information:

Dates of Service: _____ to _____ Frequency of service: _____ per _____
Agency/Organization Name: _____ Provider Name: _____
Provider/Agency Phone Number: _____
Please describe the services received (what kind of therapy/consultation, what behaviors or goals targeted, etc.): _____
_____
_____
Please describe the results in achieving goals: _____
_____
_____

Additional Behavioral Provider Information:

Dates of Service: _____ to _____ Frequency of service: _____ per _____
Agency/Organization Name: _____ Provider Name: _____
Provider/Agency Phone Number: _____
Please describe the services received (what kind of therapy/consultation, what behaviors or goals targeted, etc.): _____
_____
_____
Please describe the results in achieving goals: _____
_____

Supportive Services:

Please list any other services your child currently receives, both in school and out of school:

Service/Therapy	Location	Minutes/Week	Provider
Early Intervention Services			
Results in treating goals:			
Speech and/or language therapy			
Results in treating goals:			
Occupational Therapy			
Results in treating goals:			
Physical Therapy			
Results in treating goals:			
Vision Services			
Results in treating goals:			
Hearing Services			
Results in treating goals:			
Psychotherapy/Counseling			
Results in treating goals:			
Other:			
Results in treating goals:			

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Washington State requires that we ask the following questions:

Do you/or the family currently have any legal involvement that would impact your child's care? Example: parenting plan ☐ Yes ☐ No
If yes, please explain: _____
_____

Has the client ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations? ☐ Yes ☐ No
If yes, please explain: _____
_____

Does the client have a history of substance use, including tobacco use? ☐ Yes ☐ No
If yes, please explain: _____
_____

Does the client have a history of problem or pathological gambling or computer gaming? ☐ Yes ☐ No
If yes, please explain: _____
_____

Is the client an identified risk to themselves or others, to include self-injurious behaviors? Are they suicidal or do they pose a risk of homicide? ☐ Yes ☐ No
If yes, please explain: _____
_____

Is the individual under department of corrections (DOC) supervision? ☐ Yes ☐ No
If yes, please explain: _____
_____

Is the individual under civil or criminal court ordered mental health or substance use disorder treatment? ☐ Yes ☐ No
If yes, please explain: _____
_____

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.
If yes, please explain: _____
_____

Please enclose the following documents if available and applicable. These will be required prior to the start of services:

☐ Copy of your insurance card
☐ Copy of current IEP or IFSP
☐ Diagnostic report with DSM V criteria listed
☐ Prescription letter for ABA
☐ Copy of parenting plan

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Sendan Statement of Individual Rights

WAC 246-341-0600 Clinical—Individual rights.

You have the right to:

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;

(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited-English proficiency, and cultural differences;

(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises or to address risk of harm to the individual or others. "Reasonable" is defined as minimally invasive searches to detect contraband or invasive searches only upon the initial intake process or if there is reasonable suspicion of possession of contraband or the presence of other risk that could be used to cause harm to self or others;

(e) Be free of any sexual harassment;

(f) Be free of exploitation, including physical and financial exploitation;

(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;

(h) Participate in the development of your individual service plan and receive a copy of the plan if desired;

(i) Make a mental health advance directive consistent with chapter 71.32 RCW;

(j) Review your individual service record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections; and

(k) Submit a report to the department when you feel the agency has violated your rights or a WAC requirement regulating behavioral health agencies.

(l) (l) Receive a copy of agency grievance system procedures according to WAC 182-538D-0654 through 182-538D-0680 upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated.

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Consent for Treatment

By my signature below I consent to the child named below 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)

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)