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SENDAN CENTER
excellence in child & adolescent mental health

tel 360.305.3275
fax 360.655.5340
sendancenter.com

SENDAN PSYCHIATRY & PSYCHOTHERAPY: NEW PATIENT CHECKLIST

- ☐ Sendan Psychiatry & Psychotherapy: Policies and Procedures
- ☐ Information Regarding Mental Health Insurance Benefits
- ☐ HIPPA Notice of Privacy Practices
- ☐ Sendan Psychiatry & Psychotherapy: Child and Family Information Form (13 pages)
- ☐ Acknowledgement of Receipt of Notice of Privacy Practices
- ☐ Release of Information

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SENDAN PSYCHIATRY & PSYCHOTHERAPY: POLICIES AND PROCEDURES

Sendan Center is dedicated to providing the best care possible for our families, both in terms of clinical care, and customer service. We know that many families are coming to us at a time of stress and worry. We want you to leave us feeling fully supported.

This document provides important information about Sendan Psychiatry & Psychotherapy, and clearly lays out our policies and procedures. Our organizational policies and procedures are driven by our highest priority: the good health and wellbeing of the children and adolescents we see. In our experience, families who read this document thoroughly before the first visit, and keep a copy for reference, go on to enjoy the most satisfying relationships with Sendan Center. We ask that you carefully review the information presented and ask any questions that might arise. We have highlighted the most common areas of misunderstanding. We ask that you sign the last page to acknowledge your understanding of our procedures and your financial obligations. If you have any questions or concerns regarding any of these policies, please let us know. Again, please keep a copy of this document for reference.

Sendan Psychiatry & Psychotherapy is a division of Sendan Center, which in turn is an undertaking of Pacific Northwest Psychiatry (PNP), PS, a professional services corporation. James Harle, M.D. is the president of PNP and is board-certified by the American Board of Psychiatry and Neurology, in both Child and Adolescent Psychiatry and General Psychiatry. He completed his undergraduate studies at Stanford University and received his M.D. from the University of Washington School of Medicine. Dr. Harle completed a residency in General Psychiatry at Oregon Health and Sciences University and the Child and Adolescent Psychiatry Fellowship at Children's Hospital and Regional Medical Center and the University of Washington in Seattle. Dr. Harle is clinical adjunct faculty at the University of Washington School of Medicine.

Sendan Psychiatry and Psychotherapy provides psychiatric and psychotherapeutic consultation, evaluation and treatment of children, adolescents, and families, in a collaborative, evidence-based manner. We aspire to providing the best level of care available. We strive to have our therapists trained and mentored by nationally-recognized experts in their respective modalities, in those selected areas in which identified best practices and training opportunities exist.

Please read the information below carefully and **initial and sign as appropriate.**

INFORMATION FOR DR. HARLE'S PATIENTS AND FOR PSYCHOTHERAPY CLIENTS:

The child psychiatry / psychotherapy evaluation process

Before the initial appointment, you will be asked to download and fill out intake forms, some of which are quite lengthy. We ask that you complete these prior to arriving at your first appointment so that we may have the fullest understanding of your child and family's situation, which will enable us to arrive at the most complete and appropriate

diagnoses and treatment recommendations. Please either bring the completed forms to the first appointment or mail them in prior to your visit.

Typically, **three** sessions are needed to complete an evaluation and provide feedback regarding diagnosis, recommendations, and prognosis. During the **first** evaluative visit of a child, the clinician (Dr. Harle or the therapist) will meet with the parents without the child present; an exception to this may be if the patient is sixteen years old or older. Up to sixty minutes are available for the first evaluative visit. During the **second** evaluative visit of a child, Dr. Harle / your therapist will meet with the patient. The **third** session is for feedback regarding diagnosis, prognosis, and intervention/treatment recommendations. If your child is young enough to need supervision while parents are meeting with Dr. Harle/your therapist at any time during the evaluative process, you will need to arrange to have someone watch them.

Keep in mind that some of the questions asked are standard and asked of all families seen for evaluation. For families in the midst of a custody dispute of any kind, we require that both parents attend all sessions.

In addition to asking you about your current issues and about your family, social, and medical background, we may ask your permission to seek information from your primary care physician and past mental health and psychiatric practitioners you have seen. We will not, however, involve anyone in such a way without your expressed permission to do so, with the exception of the situations noted below. We place an extremely high value on the confidentiality of our relationship with you. If you request, we will disclose no information to those whom we ask for information about you. If you have been referred to us by your physician, we may, as a routine courtesy, pass on information summarizing our evaluation, diagnosis, and recommended treatment. Again, if you wish that we not do so, please tell us and we will honor that request.

All information obtained is confidential EXCEPT for the following situations:

- concern that someone is at immediate risk to hurt him/her-self

- concern that someone is at immediate risk to hurt someone else

- concern that someone is not able to take care of their basic needs (such as food and shelter)

- additionally, the state law of Washington requires that physicians report any case of suspected child abuse or neglect

When the psychiatric / psychotherapeutic evaluation is complete

We will discuss with you our findings and recommendations as to how to best help you. If we recommend treatment, we will recommend providers that we feel are best for your child; those providers may be within or outside our practice, depending on your child's needs. If you are seeing someone outside our practice for psychotherapy, we will ask you to permit us to have full, mutual communication with that therapist, so that we are truly working as a team. We do charge for conferences with therapists outside our practice.

Changes in health status

We ask that you keep us informed of any changes in your child's general health status and of any new medications, supplements, vitamins, herbal products, or other medical treatments any other health care practitioners may be prescribing for your child. This is important whether or not your child is taking medications as part of the psychiatric treatment.

INFORMATION FOR DR. HARLE'S PATIENTS ONLY:

General Refill Guidelines

If you need a prescription refilled, please first contact your pharmacy. Your pharmacy will fax our office a refill request. We require 48 hours advance notice of such requests, and 72 hours notice on Fridays.

If there are no refill authorizations remaining on your current prescription, your child will likely need to be seen by Dr. Harle in order to renew the prescription. Please ensure that you have scheduled an appointment with Dr. Harle well in advance of any prescriptions running out.

If the medication requires a hand-written prescription (as for stimulant medications such as Ritalin, Concerta or Vyvanse), the patient must be seen by Dr. Harle in the office before a refill prescription will be issued. Please call 360.305.3275 to schedule an appointment with Dr. Harle if your child needs a stimulant medication refill.

Our highest obligation is to your child's good health and safety. Please ensure that you carefully follow the above guidelines.

Detailed Information regarding Medication Refill Requests

First and foremost, always request medication refills well ahead of the time they are required, keeping in mind we require 48 hours advance notice of any refill, and 72 hours advance notice on Fridays. This policy is in place as the volume of refill requests on any given day can be quite high and we exercise great care in making sure your prescription refill is correctly approved. Also, please carefully read the prescription bottle label to determine whether refills are currently available. Finally, please make sure your child and family is not overdue for an appointment as if this is the case, you will be required to make one before another prescription can be authorized.

Medication refills of *stimulant* medications

Stimulant medications include Methylin, Ritalin, Concerta, Metadate, Daytrana, Vyvanse, Dexedrine, Dextrostat, dextroamphetamine, Adderall, and Mixed Amphetamine salts.

If your child is being prescribed a stimulant medication, he or she must be seen by Dr. Harle at least every three months for safety reasons. Remember refill authorizations for these medications cannot be telephoned or faxed, due to DEA regulations. Therefore, you will have to pick this prescription up at the office. If you live outside of Bellingham, we can mail this to you, but if a prescription is lost in the mail, this option is not possible. Lack of timely appointments or notification of refill requests may lead to your child not being prescribed his or her medication.

_____ (patient or responsible party's initials)

Medication refills of *non-stimulant* medications

Please contact your pharmacy to request a refill of medication as this is usually the quickest way to refill medication, even if no refill authorizations are available. We exercise great care in making sure your prescription refill is correctly approved. Therefore, it is necessary for us to have 48 hours advance notice of any refill request, and 72 hours advance notice on Fridays.

INFORMATION FOR DR. HARLE'S PATIENTS AND FOR PSYCHOTHERAPY CLIENTS:

Appointment times

We are aware that typically parents wish for their children to not miss school to attend medical appointments, however please keep in mind that we have only a limited number of appointments before or after school.

Checking in for appointments

Please check in with the receptionist, when reception is available, before each appointment. While we try to keep on schedule to avoid keeping you waiting, occasionally clinical issues put us behind. By checking in with the receptionist, you will be informed of any delays and we will be alerted that you have arrived for your appointment.

If your child is young enough to need supervision while parents are meeting with Dr. Harle or your therapist, you will need to arrange to have someone watch them.

Missed appointments

We will bill for missed visits which have not been cancelled at least 48 hours prior to the scheduled appointment time, including weekends. We understand that this may be a departure from the way many other medical offices, such as those of family physicians, deal with this issue. Please understand that, unlike other such doctors, our visits are scheduled for you alone. We cannot, like other kinds of doctors, simply go on to the next patient waiting for us in the exam room next door. We therefore charge for the time we set aside for you. We ask that you carefully keep track of your visits and consider them with the same commitment as we do. If you do cancel within less than 48 hours and we are able to fill the time by offering it to someone else, you will not be charged. However, we cannot guarantee that this will always be possible. No insurers will pay for missed visits. If you miss an appointment, we will bill you directly at the private pay (not insurance) rate. Parents are responsible for payment of missed visits by minor or dependent children. The one exception to this policy is a true emergency that affects your health. We will discuss any such circumstances with you if such an emergency causes you to miss an appointment.

_____ (patient or responsible party's initials)

Individual Therapist Appointment Policy

Some Sendan Center therapists have a unique appointment policy in which they schedule standing appointments on a fixed day and time for their regular clients in good standing, in order to provide consistency and ease of scheduling for children and families. Your individual therapist will let you know if such a policy applies to you.

Telephone calls with Front Office or Billing Staff

We try our best to return all calls within one business day and urgent calls sooner. However, this is not always possible for a variety of reasons. You can help us by always leaving your phone number and good times to reach you.

Telephone calls with Clinicians

It is often recommended to call and discuss concerns with your therapist, prior to calling Dr. Harle. Keep in mind that calls are often returned before 9am the next day or after 5pm, as Dr. Harle is seeing patients throughout the day.

We do bill for telephone calls and letters, including those required to ensure prescribed medications are approved by insurance companies. Phone conversations with your clinician (Dr. Harle or your therapist) are not a substitute for office visits, and are billed at the private pay rate; insurers typically do NOT pay for these services.

_____(patient or responsible party's initials)

Coverage by and consultation with other physicians and psychiatric nurse-practitioners

At times we will be unable to be available for urgent/emergent needs and will arrange coverage for these periods of unavailability with other psychiatrists and psychiatric nurse-practitioners.

Additionally, our providers participate in external consultation and mentoring groups with other psychiatrists , psychologists, and / or psychiatric nurse-practitioners, during which specific cases are discussed in detail, but anonymously, for the purpose of improving patient care.

Last, specific cases may be discussed by your clinician with another Sendan Center clinician, only in those circumstances in which the other clinician may be helpful to the case.

_____ (patient or responsible party's initials)

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 as we are providing patient care during office hours. For urgent, but non-emergent, concerns, you may leave a message and we will attempt to get back to you within 24 hours. For non-emergent, clinically urgent issues after-hours, please call the main clinic number and follow the paging instructions.

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Billing and Payment Policies

Payment is always due at the time of service. If the receptionist is not available to receive payment at the time of your appointment, your clinician will give you a walkout statement that shows your balance due. Envelopes are at the front counter so you can pay your clinician directly or drop payment in the front office drop slot.

If your minor or dependent child is seen, 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 don't wish to send payment with your child.

We only bill Regence, Group Health Cooperative, Premera and Health Management Administrators.

We do NOT bill any other third party payer or insurance company, including Medicare or DSHS. If you have any other insurance than those listed above, you are responsible for the bill at the time of service. You may independently submit your walkout statement and receipt to your insurance company for any possible reimbursement. It is your responsibility to know whether your insurance company will reimburse you.

If you have either Medicare or DSHS and still want to be seen at Sendan, we will need you to sign a form stating that you understand that we are not contracting with either of these agencies and that you accept full responsibility for the bill.

Please be aware that even some of these above noted insurance companies sell policies which do not cover psychiatric or other mental health services. The billing staff will be happy to assist you in seeking clarification from your insurer as to your coverage. It is your responsibility to be informed accurately about the extent of your coverage. If your insurance requires you to obtain a referral to see us prior to your visit, it is your responsibility to see that this is done.

The above-mentioned companies often have deductibles, co-payments, and co-insurance fees. We ask that these fees be paid on the day the services are performed. Also, there are services that are NOT routinely covered by insurers, such as written reports, lengthy telephone consultations, conferences with therapists outside our practice, and letters written at your request. You will be personally responsible for these charges.

_____ (patient or responsible party's initials)

A carrying fee of $5.00 is charged on all accounts with a balance due where a payment was not made that month.

Unpaid bills are submitted to a collection agency, which may result in significant additional charges, for which you will be responsible.

Please note that SENDAN PSYCHIATRY AND PSYCHOTHERAPY charges a flat fee of $20 per page for all documents requested by outside parties. These include, but are not limited to: pre-authorization of medications (requested by insurance companies); disability forms (requested by the state); medication forms (requested by schools or camps). This fee is not routinely covered by insurers. You will be personally responsible for these charges. However, this does not include the authorized exchange of chart notes or communications between Sendan Center and a primary care physician.

_____ (patient or responsible party's initials)

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Some insurers, from time to time, request information which allows them to process your insurance claims. We request that you allow us to release such information to your insurer.

Billing and Payment Problems

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 everybody's best efforts. Our staff are dedicated to approaching billing and payment conflicts from a problem-solving perspective, with patience and goodwill.

I acknowledge that I have read this document regarding policies and procedures of Sendan Psychiatry & Psychotherapy and have had an opportunity to ask questions about the information within it. I acknowledge that knowledge and understanding of my insurance benefits is solely my responsibility.

I will be responsible for payment for 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.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship

(parent, legal guardian, personal representative)

_____

Name of patient

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INFORMATION REGARDING MENTAL HEALTH INSURANCE BENEFITS

We request that you contact your insurance company to ask about your benefits. Although your insurance card may have its company name on it, the insurance company may have contracted outpatient mental health benefits to a completely different insurance company, with whom we are not contracted.

When calling your insurance company, we strongly recommend you ask the following questions, using the term "outpatient mental health benefits":

1. Is Dr. Harle / the therapist in or out of network? If Dr. Harle / the therapist is out of network, are there any outpatient mental health benefits? This will give you information about how much you will have to pay out of pocket for a visit. For an in-network provider, the client usually has to pay less out of pocket than they would for an out of network provider. Sometimes an insurance company will provide no outpatient mental health coverage for an out of network provider.
2. Do I have a deductible? If so, how much is it and how much has been met? A deductible is the amount you must pay each year before the insurance company will start to pay on your claims. With health insurance, the deductible is typically reset every calendar year. Insurance companies will not pay any claims until the deductible is met.
3. Do I have a copay and/or coinsurance? A copay is a set amount, whereas a coinsurance is a percentage. You may have a copay, a coinsurance, or both.
4. Do I need prior authorization? If so, how do I obtain this authorization? Some insurance companies will not pay if authorization is not arranged before the appointment.
5. How many visits are covered? It is your responsibility to keep track of this. Any visits for which insurance payment has been denied, including for exceeding a visit limit maximum, will be your responsibility and will not involve the insurance company.

I HAVE READ THE INFORMATION ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ANYTHING MY INSURANCE COMPANY DOES NOT PAY FOR. I AM AWARE THAT A QUOTE OF BENEFITS FROM MY INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT. I AM ALSO AWARE THAT IF MY INSURANCE COMPANY MISQUOTES BENEFIT INFORMATION TO ME, SENDAN'S BILLING DEPARTMENT OR SENDAN, THE BILL IS STILL ULTIMATELY MY RESPONSIBILITY.

Signature of Responsible Party Date

Printed name of Responsible Party

Patient Name

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CHILD AND FAMILY INFORMATION FORM

IDENTIFYING INFORMATION

Date Completed: _____

Child's name: _____ DOB: _____

Ethnicity/race: _____ Soc Sec #: _____

Gender: ☐ Male ☐ Female Primary language if other than English: _____

Person filling out this form: _____ Relationship: _____

Person(s) who assisted in completing this form: _____

PARENT/GUARDIAN INFORMATION/CHILD CUSTODY AND PLACEMENT HISTORY

Who has current custody/guardianship of child? ☐ both parents ☐ mother ☐ father

☐ relative: _____ ☐ other: _____

If the Legal Guardian is someone other than the parents, please complete the following:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

NOTE: <u>If a parenting plan exists, please provide a copy to Dr. Harle</u>.

Information about child's biologic mother:

Mother's name: _____ DOB: _____

Address: _____

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

Occupation: _____ Employer: _____

Marital status: _____ Years of education/degree: _____

General health: _____

Information about child's biologic father:

Father's name: _____ DOB: _____

Address: _____

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

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Occupation: _____ Employer: _____

Marital status: _____ Years of education/degree: _____

General health: _____

Stepmother's name (if applicable): _____

Stepfather's name (if applicable): _____

Emergency contact: _____ Relationship: _____

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

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

Name	Gender	Age	Relationship
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Has the family had moved in the past 12 months? ☐ Yes ☐ No If yes, how many times? _____

Has the family experienced homelessness in the past 12 months? ☐ Yes ☐ No

OUT-OF-HOME PLACEMENT HISTORY (IF APPLICABLE)

Has the child ever been separated from his/her parents or primary caregivers for any significant period of time?
☐ Yes ☐ No

Provide information about the child's age and circumstances of the separation: _____

How did the separation affect the child?: _____

Is the child currently at risk for out-of-home placement? ☐ Yes ☐ No If yes, why: _____

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REASONS FOR EVALUATION

Who referred you to this practice? _____

Please state your concerns, providing as much detail as possible, including the nature of the concern, 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 to get from this evaluation/treatment? _____

BIRTH AND EARLY INFANCY HISTORY

This information should be provided as it relates to the biologic parents of the child, if known.

Was the pregnancy planned? ☐ Yes ☐ No

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Any difficulty becoming pregnant? If so, please explain: _____

_____

Was the mother exposed to any of the following:

TYPE	LIST SPECIFIC SUBSTANCES	AMOUNT	MONTH OF PREGNANCY
DRUGS	☐ None		
ALCOHOL	☐ None		
TOBACCO	☐ None		
MEDICATIONS	☐ None		
X-RAYS	☐ None		

Did the mother experience any health problems during pregnancy? ☐ Yes ☐ No If yes, please describe:

_____

Length of pregnancy: _____ Age of mother: _____ Weight gain: _____

Describe labor and/or delivery with this child: ☐ Without problem ☐ Difficult (please explain below)

☐ Natural (vaginal) ☐ C-section ☐ Forceps used Please explain: _____

_____

Did the baby cry immediately after birth? ☐ Yes ☐ No Apgar scores (if known): _____

Birth statistics: Weight: _____ Length: _____ Head circumference: _____

How soon after the birth did the mother see the baby? _____ Hold the baby? _____

Hospital where the child was born: _____

Duration of mother's hospital stay: _____ Baby's hospital stay: _____

Were there any problems noted by anyone while the baby was still in the hospital? (For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____

_____

_____

Were there any difficulties during the baby's first month of life? (Examples: excessive crying, health problems):

_____

_____

Was infant ☐ bottle or ☐ breast fed? Number of months breast fed: _____

Were there any difficulties with feeding? (Examples: recurrent vomiting, "colic", poor suck, low weight gain)

_____

Did parents have significant or unusual trouble adjusting to the new baby? _____

_____

Did biologic mother suffer with postpartum blues or depression? If so, please describe._____

DEVELOPMENTAL HISTORY

Do you / did you have any concerns about your child's development? ☐ Yes ☐ No.

Was development perceived as ☐ average? ☐ below average? ☐ above average?

Please identify your child's developmental progress in the following areas:

Areas of Development	***Compare your child's development to other children his/her age (please put an X in the box below):***			***Please comment on areas of strength and needs in your child's development:***
	Average	Slower	Faster	Please note any delay/ deterioration/ loss of skills
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				

Has your child had any formal developmental testing? ☐ Yes ☐ No If yes, please provide details: _____

Has your child received any early intervention services? ☐ Yes ☐ No If yes, please provide details: _____

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is your child's primary doctor? _____ Phone #: _____

Address: _____

Who is your child's primary dentist? _____ Phone #: _____

When was your child last seen by a medical professional? _____

For what reason? _____

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Date and results of last physical examination: _____

Child's current height: _____ weight: _____ Is your child's general physical health good? ☐ Yes ☐ No

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

Any sleep problems? _____

Typical range of times when your child falls asleep on school nights: _____ Non-school nights: _____

Typical range of times when your child gets up on school days: _____ Non-school days: _____

Does your child snore, gag, or ever appear to stop breathing during sleep? _____

Does your child have a television or computer in their bedroom? _____

Does your child have access to video games in their bedroom at night? _____

How does your child wind down at the end of the day? _____

Are immunizations up to date? ☐ Yes ☐ No

Does your child 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

Has child had any history of seizures/convulsions (including with exercise, startle, or fright) or head injury/concussion? ☐ Yes ☐ No If yes, please provide details _____

_____

Has your child had any serious injuries/accidents? ☐ Yes ☐ No If yes, please provide details: _____

_____

Has your child 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 medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

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

Current	Past	Name of treatment:	Condition(s):	Prescribing MD:	Response/side effects:

Has your child 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 other children of the same age) in the absence of an alternative explanation (eg, asthma, sedentary lifestyle, obesity) _____
- ❑ poor exercise tolerance (in comparison with other children) in the absence of an alternative explanation such as asthma, sedentary lifestyle, or obesity _____
- ❑ palpitations brought on by exercise _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No If yes, explain: _____

_____

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

_____

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FAMILY MEDICAL HISTORY

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

Check all that apply, past or present:

Condition/Circumstance	Child	Mother	Father	Sibling(s)	Mother's Family	Father's Family
Mental Retardation						
Epilepsy/Convulsions						
ADD or ADHD						
Learning Disorder						
Schizophrenia						
Alcohol Abuse						
Drug Abuse						
Physical Abuse						
Sexual Abuse						
Emotional Abuse						
Depression						
Suicide or Suicide Attempts						
Mania / Bipolar Disorder						
Anxiety Disorder						
Panic Attacks						
OCD						
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						
Other:_____						

Is 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:_____

_____

_____

CHILD SOCIAL-BEHAVIORAL AND PSYCHIATRIC HISTORY

How is your child's overall emotional health? _____

_____

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 medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

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

Type of service	Service provider/address	Results	Dates

Does your child have behavior problems at home? If so, please specify: _____

_____

_____

Does your child have behavior problems at school? If so, please specify: _____

_____

_____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc)? If so, please specify: _____

_____

_____

Does your child have any past or current substance use/abuse? ☐ cigarettes ☐ drugs ☐ alcohol ☐ denies use ☐ none If yes, please describe substances used, amount, and effect on child: _____

_____

_____

Has the child engaged in any law breaking behavior? ☐ Yes ☐ No If yes, please provide details: _____

_____

Has your child had any history of the following emotional/behavioral problems:

- ☐ specific phobias/fears: _____
- ☐ firesetting: _____
- ☐ harming animals: _____
- ☐ hurting him/herself on purpose: _____

History of violence/grief and loss:

Has child been exposed to violence or fighting between parents? ☐ Yes ☐ No

Has child been a witness to violence or traumatic death? ☐ Yes ☐ No

Has child experienced death of parent/psychological parent/sibling? ☐ Yes ☐ No

Child abuse/neglect history:

☐ Not applicable. Child has a 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? _____

_____

_____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

_____

_____

_____

Please make a brief statement about the relationship between your child and

Mother/maternal caregiver: _____

Father/paternal caregiver: _____

Siblings: _____

The closest relationship is between your child and _____

The most troubled relationship is between your child and _____

How has your child's problem affected each family member?:

Mother: _____

Father: _____

Sibling(s): _____

Describe sleeping arrangements in the family: _____

_____

Does your child participate in any community activities (e.g. sports, Boys & Girls Club, church)? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does your child have hobbies, interests, etc? _____

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What games/activities does your child prefer? _____

Does your child have a social network account? (eg, MySpace, Facebook)_____

Do you have access to this?_____

Where are the televisions and computers in your home?_____

Do the computers have parental controls?_____

Does your child have any portable electronic devices that can access the Internet?_____

How many hours does your child spend in front of any screen on a typical school day?_____

How many hours does your child spend in front of any screen on a typical non-school day?_____

Are chores routinely assigned to your child? ☐ Yes ☐ No If yes, which chores? _____

Does your child have as many friends as most other children his/her age? ☐ Yes ☐ No

Does your child have friends come over and play/socialize at your house? ☐ Yes ☐ No

Does your child play at the houses of his/her friends? ☐ Yes ☐ No

Has your child had any friends stay overnight at your house, or has she/he stayed overnight at another friend's house? ☐ Yes ☐ No ☐ Not age-appropriate (child too young)

Has your child been persistently harassed or abused by peers? ☐ Yes ☐ No

Please list those qualities about your child that you consider to be strong positive points. _____

Please list those qualities about your child that you consider to be strong negative points. _____

SCHOOL/VOCATIONAL HISTORY

Is your child currently enrolled in school? ☐ Yes ☐ No

Current school placement:

School Name: _____ Grade: _____

School District: _____ Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Is your child enrolled in special education? ☐ Yes ☐ No Current I.E.P.? ☐ 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 your child is currently functioning at school? _____

_____

_____

_____

Review history of school placements and functioning: (including learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement): _____

_____

_____

_____

_____

Has your child been suspended/expelled in past 12 months? ☐ Yes ☐ No If so, how many times? _____

_____

What school interventions have been used to address problems: ☐ None ☐ Special seating arrangement

☐ Tutoring ☐ Token economy ☐ Groups ☐ Classroom aide ☐ Parent(s) called ☐ other:_____

Vocational History: ☐ Not applicable

Has your child had any paid employment? ☐ Yes ☐ No If yes, provide details of employment history: _____

_____

Has your child had any significant volunteer experiences? ☐ Yes ☐ No If yes, provide details: _____

_____

FAMILY HISTORY

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

Please describe activities that your family likes to do together: _____

_____

_____

Are there currently any unusual stresses your family is experiencing? ☐ Yes ☐ No

Is there any problematic family conflict currently in the household in which the child resides? ☐ Yes ☐ No

Does patient have a troubled sibling? ☐Yes ☐ No

If you answered yes to any of above 3 questions, please provide details and effect on child: _____

_____

_____

_____

Please provide a brief statement about parents'/caregivers' own relationship: _____

_____

_____

Has there been any domestic violence in the household in which the child resides? ☐ Yes ☐ No

If yes, please provide details (Police called? Legal consequences? Effect on child?): _____

_____

_____

Are there any guns in your home or any home your child visits?_____

If so, are the guns locked? ☐ Yes ☐ No If yes, how?_____

Does parent/caregiver have a history of alcohol or drug use, which disrupts his/her capacity to parent?

☐ Yes ☐ No If yes, provide details_____

_____

Has parent/caregiver ever been involved in the criminal justice system? ☐ Yes ☐ No If yes, provide details:_____

_____

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

HEALTH BELIEFS/CULTURAL ASSESSMENT [PER WAC 275-57-410-2]

Ethnic/cultural identification of parent/child/extended family: _____

Language spoken at home_____

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

_____

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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 about your child or family that we did not ask? _____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form.

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

We respect your privacy and understand that your chart is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your chart includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
• Information obtained will be recorded in your medical record and used to help decide what care may be right for you.
• We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:
• We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:
• We use your medical records to assess quality and improve services.
• We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
• We may use and disclose your information to conduct or arrange for services, including:
• medical quality review by your health plan;
• accounting, legal, risk management, and insurance services;
• audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:
• Receive, read, and ask questions about this Notice;
• Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us and we will try to comply with any request made;
• Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information.
• Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
• Have us review a denial of access to your health information—except in certain circumstances;
• Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
• When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
• Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
• Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact our Privacy Officer at 671-0383.

Our Responsibilities

We are required to:
• Keep your protected health information private;
• Give you this Notice;
• Follow the terms of this Notice.
We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or to Register a Complaint:
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may our Privacy Officer at 671-0383.
If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will take your complaint as constructive criticism and will not retaliate against you.

We may use and disclose your protected health information without your authorization as follows:

• **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information.
• **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
• **For Public Health and Safety Purposes as Allowed or Required by Law:**
• to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
• to public health or legal authorities
• to protect public health and safety
• to prevent or control disease, injury, or disability
• to report vital statistics such as births or deaths.
• **To Report Suspected Abuse or Neglect** to public authorities.
• **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
• **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
• **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
• **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
• **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
• **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
• **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
• **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

• Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: 04/06/2011

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see and Copy of that record. You may also ask to correct that record.

We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may obtain more information by contacting our Privacy Officer at 360-305-3275.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____

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 your medical record.

Last Update: 09/15/2011

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Release of Information

Authorization for SENDAN CENTER to mutually exchange my Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may mutually exchange my health care information under this Authorization with:

1. Name (or title) and organization: _____
   Address (if not local): _____

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record, including insurance/financial information
- ☐ Most recent progress note, problem list, medication list, laboratory study results, psycho-social history including psychiatric and substance use-related
- ☐ Summary of mental health/psychiatric/psychological assessment and treatment
- ☐ Ongoing communication regarding mental health/psychiatric/psychological care
- ☐ Communication regarding academic performance and behavior of youth in school setting, Individual Education Plan (IEP) or section 504 accommodations, psycho-educational testing
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X rays, bills); specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use
- ☐ Sexually transmitted diseases
- ☐ HIV (AIDS virus)

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify)

- ☐ **This authorization ends:**
- ☐ on (date): _____
- ☐ when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Sendan Center employees, based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I may complete a cancellation form available from Sendan Center.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient 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)