

Lester M. Sandman, M.D.

14205 SE 36th St.
Suite 100
Bellevue, WA 98006
425-889-6879
Fax: 425-889-0366

Date: _____

Patient Name: _____

Date of Birth: _____ Male: ___ Female: ___

Address: _____ Phones: Home: _____

Cell: _____

Work: _____

City Zip

.....

Please indicate all phone numbers where we may call and leave information for appointment reminders and to contact you for other clinical concerns. Please list any other numbers where we may call and leave information about you:

Please list any phone numbers you have provided elsewhere that you **NEVER** want us to use:

Please list all available emergency contact phone numbers not in your household:

Who may we thank for referring you?

If a physician or a counselor please provide their phone and fax number:

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DISCLOSURE AND CONSENT FOR TREATMENT

Dear Patient:

There are a few issues you should understand while receiving treatment here. If you have any questions about these or any other topics, PLEASE ask our staff or the doctor.

Separate Professionals:

The doctor shares office space with other independently licensed professionals. We are not in any more extensive business or clinical relationship beyond sharing office space (e.g. the doctor does not provide supervision or share in clinical decision making with others in the office).

Appointments, Cancellations/Missed Appointments, After Hours & Emergencies:

Generally, during periods of instability, medication management follow up visits are scheduled every 2-8 weeks. Follow up appointments are usually recommended when important decisions will likely be necessary & not more frequently, in order to make our appointment frequency as efficient as possible. However you are welcome to come in more often if you wish. Most patients prefer brief medication management time slots as the most efficient, however you prefer longer visits, check with the doctor to make arrangements. Since appointments can sometimes fill out for weeks, you may wish to schedule more than one follow up visit in advance, to be sure to meet your needs. Please note, insurance reimbursement is usually less for longer appointments.

Scheduled appointment times are reserved especially for you at the time of your visit or by calling the office. **If an appointment is missed or canceled with less than two full business days notice, you will be charged for that appointment.** Repeatedly not showing for appointments could result in discontinuing further care. **Your insurance company generally will not reimburse for fees associated with missed or canceled appointments.** Our office will attempt to provide an appointment reminder call, however this is a courtesy call and **we make no guarantee of such a call.** Our inability to reach you does not imply the appointment is cancelled or that a missed appointment fee will be waived.

The office phone system has after hours voice mail and contact information. If you have an immediate life-threatening emergency (medical or psychiatric, including suicide risk), call 911 rather than the office or after hour lines (which could result in too much of a delay). Your physician can be reached after office hours or will arrange for another doctor to cover. Generally, problems that arise between sessions can and should be managed by scheduling an earlier appointment, or if more urgent, coming to urgent walk-in appointments usually available twice a week. Always check with the front desk for available times of walk-ins. For after hours emergencies, defined as a problem you feel may be unsafe to wait until the next available appointment or walk-in time, follow the office voice mail instructions for emergency doctor notification.

Pregnancy:

Many prescription drugs are potentially toxic to the fetus. If you are treated with medications here, please let your doctor know if at any time you think you may be pregnant or if you are not properly protected.

Driving and operating machinery:

Many psychiatric medications can affect your level of alertness or your speed of reflexes. Please exercise extreme caution when driving or operating machinery if you have recently been started on a new medication or if your dose was recently changed.

Medicare:

Dr. Sandman has "opted out" of Medicare. This means he is legally required not to bill Medicare for any services. This was NOT done because of reimbursement. Rather, it is because the Federal Government, in its effort to seek out anyone who might cheat Medicare, has gone after physicians with criminal law and severe penalties including jail time. You can imagine with an aggressive prosecutor trying to make a name for him/herself how this might go. If you are Medicare eligible, by law we must sign a separate "contract."

Patient Name: _____

Signature of Patient (or guarantor) _____ Date: _____

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Lester M. Sandman, M.D. ("the Doctor") provides psychiatric treatment for:

_____ ("the Patient").

The doctor has taken the "Country Doctor Exclusion" from HIPAA and maintains patient privacy under Washington State Law. The Doctor has done this in part because the Doctor believes HIPPA is LESS protective of privacy than Washington State Law (see addendum for exceptions to Washington State Law.)

The Doctor maintains this high level of privacy even when it is detrimental to the Doctor personally or to his practice. In the last few years with the rapid expansion of uncontrolled information on the Internet, it has become possible for anyone, a patient, an unrelated person, or even competitor, to anonymously make public, untrue, disparaging or defamatory statements about any physician. The sites publishing these comments are immune from any liability for such comments. The Doctor, because of his high level of confidentiality, may not be able to provide a rebuttle to these public comments.

In consideration for treatment provided to the patient with this level of privacy protection, Patient agrees to refrain from directly or indirectly publishing or airing in any media (by name, anonymously, or by pseudonym), any positive or negative commentary upon the Doctor, his staff, or his practice. The Patient will also use all reasonable efforts to prevent any family member or acquaintance from engaging in such activity.

As a matter of office policy, the Doctor is requiring all patients in his practice to sign the Mutual Agreement to Maintain privacy. Should the Patient breach this Agreement, the Patient understands that treatment may be terminated. Also, in the event of a breach of this Agreement, the Patient consents in advance to release any and all medical, psychiatric, and personal information that the Doctor believes is necessary in order to make an adequate public rebuttle.

So agreed this _____ day of _____, 20____

_____ (Patient)

_____ (Doctor)

Lester M. Sandman, M.D., Inc. P.S.

Addendum to Mutual Agreement to Maintain Privacy:

Washington State law does have some exceptions to the legal requirement for confidentiality:

- 1) In general, we must have your written release to provide information to others. Exceptions in which we may be compelled by law to break confidentiality of your medical records includes serious danger to yourself or others, suspected child abuse or elder abuse, inability to meet basic needs such as food or shelter, or a court order. State law allows clinical information to be exchanged with other current treating professionals without your consent for continuity of ongoing medical care. The usual office procedure is to forward information about your treatment to other treating clinicians. Your doctor will make every effort to discuss these issues prior to any unusual disclosure. **Please inform your doctor if you do not wish medical information released to any of your current or future treating professionals.**
- 2) Your health insurance may request information in order to determine if they will cover your services (generally you will already have given consent). Your insurance company may also require disclosure of your diagnosis when laboratory tests are ordered. If you do not wish to comply with your insurance requests, please tell your doctor.
- 3) Confidentiality may not fully apply to couples, family, and group sessions.
- 4) Parents and custodians may share in the confidentiality of a minor. Generally this requires further discussion.
- 5) If you are being seen at the direction of another agency (for example, disability evaluation), you may not have confidentiality.
- 6) Frequently, immediate family members will call and ask for information. If, in good faith, we believe your family member already knows that you are being seen at our clinic, we will generally acknowledge that fact. Beyond that, we usually ask that information for family is passed through you or passed on in your presence.
- 7) Unless you instruct us otherwise, we will attempt to make a courtesy call to remind you of your upcoming appointment (see Disclosure and Consent for Treatment). Please be aware that our calls may be identified by any phone equipped with "caller I.D."
- 8) If you wish the highest level of confidentiality, you must not use your insurance and not provide collateral information to other treating professionals. Your records will then remain only in this office. We will not use our billing service, so all fees would be due at the time of your visit.
- 9) Dr. Sandman has elected to take the "country doctor exclusion" from HIPPA (the federal privacy laws of 2003.) It is our belief that these laws **lower** privacy standards over Washington State Law by allowing more information exchange without your consent. However information passed on to your other treating professionals such as your primary care doctor may transfer information to a HIPPA compliant clinic.

Any future changes in office privacy practices will be at the doctor's discretion and will comply with applicable law.

Fees and Services Between Visits

The doctor has returned to the "old school" method of billing. Services performed, in your presence and on your behalf between visits, will be billed entirely based on time. Since "staff time" is less expensive than "doctor time", whenever possible we will try to keep fees to a minimum by using staff time first. Fees for service, performed at your appointment and on your behalf between appointments, will be due in full at each appointment. You will be provided an invoice at each visit (and our accounting service will send you a "HCFA form") that you can use for obtaining reimbursement from an insurance company.

Unless you instruct us otherwise, properly authorized requests between visits for medical information or action on your behalf, will be honored as endorsed by you (and will be billed at the usual rate). Such activities might include (but are not limited to) refill requests, medication prior authorizations, insurance requests for records to support billing activities, disability insurance requests for clinical updates, etc. We will make every effort to alert you first if we anticipate an extensive time request. If you are using insurance, we recommend you schedule a visit if you anticipate these activities, since face-to-face meetings are usually reimbursable from an insurance company.

Telephone calls (other than scheduling) are billed at the usual rate. A regularly scheduled phone appointment will require a credit card payment that day. Please note, insurance usually will not reimburse for telephone calls

Consent and Authorization for Treatment

I request Dr. Lester Sandman to provide myself with medical/psychiatric/psychological services.

I agree to pay for any and all services provided on my behalf in full at each appointment Please Initial ____

I agree to pay for all services provided on my behalf between appointments in full at the next appointment. Please Initial ____

I agree to pay for scheduled appointment cancelled less than two business days prior, or no shows at the next appointment. Please Initial ____

Patient Name: _____

Signature of Patient or Guarantor: _____

Date: _____

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NEW PATIENT HEALTH INFORMATION

*The purpose of this questionnaire is to make the first visit more comprehensive as well as efficient.
Please answer the following as completely as you can:*

Date: _____

Name: _____

Age: _____ Date of Birth: _____

Referred by: _____

Reason for referral: _____

Your current mental health providers:

Phone Numbers:

Primary care provider:

Any other health care providers?

CURRENT AND PAST MENTAL HEALTH TREATMENT

Please list any present or past psychiatric treatment, counseling, psychotherapy, family therapy or chemical dependency treatment:

Dates: **Clinician name & degree:** **Type of treatment:**

Have you ever been in a psychiatric or alcohol/drug rehabilitation hospital?

Dates: **Name of hospital/Clinic:** **Reason:**

Are you currently on or have you taken medications for a psychiatric or nervous condition in the past?

Date started: **Date stopped:** **Medication and dose:** **Result:**

Are you currently on any other medications for any other reason?

Allergies and medication reactions (please describe reaction):

PRESENTING PROBLEMS: Please indicate if absent, mild, moderate, or severe? How long?

sad or flat mood

slowed thinking

trouble making decisions

reduced enjoyment/interest

easy crying

low energy

decreased sex drive

social withdrawal

elevated or giddy mood

irritability

mind racing

impulsive decision-making

talking fast or a lot

excess energy/agitation

increased sex drive

anxiety

panic (time-limited, overwhelming)

**compelled to do something repeatedly
(checking locks, washing hands, etc.)**

Hoarding, having difficulty throwing things away

**hallucinations (hearing or seeing
things that may not be there)**

paranoid (feeling like others are watching or following you)

difficulty concentrating/focusing

suicidal thoughts/impulses/plans

suicide attempts - when, how

non-suicidal self-harm - when, how

thoughts of physically hurting others

acting violently toward others - when, how

vomiting or laxatives for weight loss

MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Please list all hospitalizations for medical (non-psychiatric) illness, injury or surgery:

<u>Date</u>	<u>Hospital Name</u>	<u>Reason for hospitalization</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems:

YES NO WHEN

- _____ _____ _____ Fainting or passing out
- _____ _____ _____ Unexplained loss of body function
- _____ _____ _____ Loss of the ability to use a body part
- _____ _____ _____ Seizures
- _____ _____ _____ Unexplained dizziness/vertigo in last year
- _____ _____ _____ Change in sense of smell
- _____ _____ _____ Unexplained trouble speaking
- _____ _____ _____ Memory trouble that concerned you
- _____ _____ _____ Blow to the head with any loss of consciousness or memory
- _____ _____ _____ Unexplained loss of a period of time
- _____ _____ _____ Smelling foul or burning odor that may not be there
- _____ _____ _____ Told you have glaucoma
- _____ _____ _____ Headaches not relieved with aspirin/Tylenol in last year

- _____ _____ _____ Diagnosed with cancer
- _____ _____ _____ Unexplained fever in last year
- _____ _____ _____ Diagnosed with a heart problem
- _____ _____ _____ Diagnosed with an artery or vein problem

- _____ _____ _____ Diagnosis of a lung problem
- _____ _____ _____ Told you snore heavily

- _____ _____ _____ Diagnosed with a stomach, liver, intestine, or gallbladder problem
- _____ _____ _____ Had jaundice (yellow skin)
- _____ _____ _____ Diagnosed with a kidney or bladder problem

_____ Diagnosed with a sexually transmitted disease Type of disease: _____
_____ Told you have a bleeding or clotting disorder
_____ Told you have anemia
_____ Told you have a thyroid or other gland problem
_____ Noticed a change in your tolerance of heat or cold
_____ Told you have diabetes

_____ Unexplained darkening of skin
_____ Low blood pressure
_____ Weight gain () loss () How much _____
_____ Unexplained nausea & vomiting in last year
_____ Excessive fatigue & weakness in the last year
_____ High blood pressure
_____ Easy bruising in last year
_____ Skin thinning with purple marks (no bruises)
_____ Fracture in last 5 years
_____ Told you have osteoporosis

_____ Unexplained abdominal pain in the past year
_____ Regularly exposed to industrial toxins, (e.g., pesticides, mercury,
Manganese, rubber and/or rayon solvent)

For women:

_____ Diagnosed with breast, uterine, cervical and/or ovary problem
_____ Hot flashes
_____ Used birth control pills in the last year
_____ Could be currently pregnant or wish to become pregnant soon

Current form of birth control: _____

FAMILY OF ORIGIN

Biological parents together until you were 18 years old? _____

Biological parents divorced? If so, when _____

Mother: Age _____ Cause of death if deceased _____

Father: Age _____ Cause of death if deceased _____

Number of siblings _____

TRAUMA HISTORY

Sexually or physically abused: () Yes () No If yes:

By whom _____

At what age _____

Experienced war or natural disaster: () Yes () No If yes:

Nature of experience _____

When _____

LEGAL HISTORY

(Arrests, convictions, imprisonment, probation, current legal problems) _____

MILITARY HISTORY

Served in military: () Yes () No. If yes:

Currently: () active duty () reserve () retired () discharged

Highest rank _____

Disciplinary actions _____

Awards _____

EDUCATION

() High school degree

() GED

() College credits. If so, number of years attended _____

Degrees received: _____

() Currently in school. If so, where _____

OCCUPATION:

Currently working? _____ Employer and description of job, (include homemaking and parenting) _____

How long? _____

Please list important prior occupation(s):

Dates: _____ Type of work: _____

CURRENT CIRCUMSTANCES:

Married ? _____ years current marriage _____ number previous marriages _____

Committed (not married) relationship? _____ how long _____

Age of spouse or partner _____ Occupation of spouse or partner _____

Divorced? _____ Number of divorces _____ when? _____

Separated? _____ when? _____

Never married? _____ Widowed? _____ when? _____

Number of children _____ Youngest age _____ Oldest age _____

Who is currently in your household? _____

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Directions to Our Office:

If traveling by freeway, please note that some map systems that direct drivers to I-90 eastbound use an exit for 142nd PL SE. **This is an HOV-only exit.** Instead you can use the 150th Ave SE exit.

Also note that 148th Ave SE and 150th Ave SE are the same road. But, if you are exiting from I-90, the 148th Ave SE exit is northbound only. You want the 150th Ave (which is southbound).

From Bothell, Kirkland & Redmond

- Proceed to I-405 South
- After SE 8th exit follow directions to merge onto I-90 East via exit 11 toward Spokane
- Take the 150th Ave exit
- Keep right, follow signs for 150th Ave SE and SE 37th St
- Turn right onto 150th Ave SE
- Immediately turn right again onto SE 36th St
- Travel 0.4 miles and the destination (14205) will be on your left

From Renton:

- Proceed to I-405 North
- After the Coal Creek, take exit 11 and merge onto I-90 East toward Spokane
- Take the 150th Ave exit
- Keep right, follow signs for 150th Ave SE and SE 37th St
- Turn right onto 150th Ave SE
- Immediately turn right again onto SE 36th St
- Travel 0.4 miles and the destination (14205) will be on your left

From Seattle:

- Proceed to I-90 Eastbound
- Take exit 10B toward Factoria/Richards Road
- After the exit proceed straight onto SE 36th St up the hill
- Travel 0.9 miles and the destination (14205) is on your right

Overlake from Bellevue:

- From NE 8th St, travel east to 148th Ave NE. Turn south (right) onto 148th Ave NE
- After crossing Main Street, 148th Ave NE becomes 148th SE. Continue southbound
- As 148th Ave SE crosses over I-90 it becomes 150th Ave SE. Continue Southbound on the overpass over I-90
- After passing the entrance onto I-90, cross through one stoplight (for I-90 off ramp)
- Take the next right at the light, onto S 36th St. (Note S 36th St becomes S. 38th St to your left)
- Continue on S 36th St for 0.4 miles.
- The destination (14205) is on your left