Richard Bingham, M.D.

www.whatsupdoc.us

528 Cottage Street NE, Suite 1D
Salem, OR 97301
V: 503-584-9923; F:503-584-0303

Dear Parent/Patient:

Enclosed is your new patient packet. Please complete the forms and return back to our office with the onetime $55.00 clinical fee as discussed. Once we have both the initial registration paperwork and the clinical fee back, we will give you a call to schedule the first initial appointment. Appointments are generally 8-10 weeks out from the time we receive your information. If you need care before the set appointment, keep involved with your primary care or current therapist until you are able to attend your first appointment. Once we schedule your appointment, further questionnaires will be sent out at this time. Please complete and have these forms returned back at our office along with any relevant information, before your appointment.

In Regard to Ongoing Care:

Many parents who seek my help for their kids are hoping that I can provide therapy as well as the specialized care provided by me as a psychiatrist. I am sorry to say that I am very unlikely to be available to be your child/adolescent's therapist at the time of the Assessment. I want to be sure you understand this so you won't be disappointed when we first meet., and so you can also look for a therapist now. I am a psychotherapist. Therapy is critical and needed by almost all patients who come for a Psychiatric Assessment. Many new patients are already working with a therapist. I do provide full therapy (45" visit every 1-2 weeks) for a very limited number of my patients. I do not usually provide long-term therapy; this means the course of therapy is usually 3 to 12 months in length. There is only enough time in my schedule to have about ten patients in therapy. I will finish therapy with a patient and then have an opening, and usually fill that with someone I am already working with to provide psychiatric care. So, there often is an opportunity, maybe 3 to 12 months later, for me to provide some therapy.

If you do not already have a therapist involved, I strongly recommend that you find one. This does not replace the Psychiatric Assessment we have scheduled. The therapy and the Assessment are different, but each provide helpful and important functions.

I will be available and would be pleased to provide ongoing psychiatric care following the Assessment. These visits are 20" long. Psychiatric care means continuing to clarify diagnosis and understanding of the factors, whether biological or psychological or social, which contribute to the problems. I provide limited therapy during these visits along with education, parent guidance, and support. Medication treatment is frequently part of this treatment.

If you have any further questions please feel free to contact our office at 503-584-9923.

Sincerely,
Richard Bingham, M.D., LLC

PATIENT REGISTRATION FORM

Richard Bingham, MD and Julie Bingham, Ph.D.

Date: _____

Patient Name		Gender M F	DOB
Street		City	
State	Zip Code	Phone	
Mother Name		Address	
Mother's Employer	Occupation		Home #: Work#:
Father's Name		Address	
Father's Employer	Occupation		Home#: Work#:
Step parent's Name		Address:	
Step parents Employer	Occupation		Home# Work#
If divorced describe custody status			
Identify Adults with whom the child lives Parents Other (please explain)			
In case of emergency, who do we notify (other than parents) Name:			
Relationship to Patient:		Home #	Work#
Patients Marital Status: Married Single Divorced Spouses name:			
Referred by:		Primary Care Physician	
Preferred Pharmacy:			

INSURANCE / BILLING INFORMATION

Responsible Party	Relationship to Patient	
Address	Phone	

Primary Insurance		ID#	Grp#
Insurance Address		Phone	
Policer Holders Name	DOB:	Employer	

Secondary Insurance		ID#	Grp#
Insurance Address		Phone	
Policer Holders Name	DOB:	Employer	

AGREEMENT TO CONDITIONS OF MEDICAL CONSULTATION OR TREATMENT

Richard D. Bingham, M.D.; Physician: Child, Adolescent and General Psychiatry

MEDICAL CONSENT: I wish for my child or myself to have a medical psychiatric evaluation by Dr. Bingham. If appropriate and available I also wish for my child or myself to become a patient of Dr. Bingham. I authorize Dr. Bingham or any other physician authorized by him to provide such medical services, either regular or emergency, as may be determined to be in the best interest of my child or myself who are under his care. This authorization shall continue and be in full force and effect until revoked in writing by me.

I have read the above and fully understand it, and have asked questions about anything not clear to me, and am satisfied with the answers I have received. I am the patient's parent, legal guardian, or the adult patient or I am legally authorized to consent on behalf of the patient.

Print Patient's Name: _____

_____ _____

Date Parent, Legal Guardian, Adult Patient

_____ _____

Date Adolescent Patient's Assent or Consent

AUTHORIZATION TO RELEASE INFORMATION TO INSURER: I authorize Dr. Bingham to release from my medical records any information required by my insurance carrier or any person, corporation, or agency responsible for managing the care or processing my claims for medical and psychiatric insurance benefits. I understand that if an insurance company or government agency is paying for my medical or psychiatric care, they may have access to sensitive information about my diagnosis and treatment. This authorization is valid for the life of the claim.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to Dr. Bingham of all insurance or health plan benefits otherwise payable to me, to the extent of the patient's bill.

FINANCIAL AGREEMENT: I agree to pay Dr. Bingham for services provided to me. **I understand I am financially responsible for charges not covered by my medical insurance. If Dr. Bingham has a contract with my insurance company, I understand that I am responsible for any deductible and copay or coinsurance which is to be paid at the time of the service. If Dr. Bingham does not have a contract with my insurance company, I understand that I am responsible for paying the whole fee at the time of the service.** All accounts are payable in full at time of billing. Accounts not paid at the time of the next months billing will accrue an interest charge of 1% of the previous month's unpaid balance. If after 60 days the insurance payment is not received, then the balance in full becomes my responsibility. If this account is placed in the hands of an attorney or collection agency, I will pay reasonable attorney's fees and collection costs, whether or not a suit is filed.

I certify that I have read the above, including the financial agreement, and fully understand it. I am the patient's parent, legal guardian, or the adult patient or I am legally authorized to execute and accept the terms of this agreement on behalf of the patient. I assume individually all financial responsibility by noting my signature below.

_____ _____ _____

Date Parent, Legal Guardian, Adult Patient Print Your Name & Relationship to Child

Person Assuming Financial Responsibility

Richard Bingham, M.D.
Board Certified in Pediatric & General Psychiatry
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AGREEMENT

Dr. Bingham agrees to do a psychiatric assessment once this has been scheduled. Whether he does any treatment following that assessment will be decided together at the end of the assessment session. Whether he can to do follow-up treatment will depend on how full his schedule is, the nature and severity of the problem and the availability of other resources in the community (including the primary care physician's ability to do the treatment).

When Dr. Bingham does do ongoing psychiatric care this involves medication treatment (usually), treatment response monitoring, focused and limited psychotherapy in short (10 to 20 minute) sessions, education and guidance, and when needed re-evaluation. Psychotherapy is almost always an important part of psychiatric treatment, and this may be especially true for children and adolescents. Dr. Bingham does do psychotherapy, but currently is unable to take any new patients for this aspect of treatment. Therefore you should have or find a therapist. You and your child will then have a *collaborative treatment* team (both a therapist and a psychiatrist); this is quite common.

If Dr. Bingham has a contract with my insurer (i.e. he is a "provider"---see the website), then I am responsible for the copay or co-insurance, and any unmet deductible at the time of the visit. If Dr. Bingham does not have a contract with my insurer (and he does not do single-case agreements), then I will send in the $290 fee for the initial appointment with this agreement. And thereafter I will pay the fee at the time of the visit. Dr. Bingham will provide a bill which may be submitted to my insurance for reimbursement.

If there are service charges which are not covered by my insurance, and Dr. Bingham can reasonably anticipate those, then he will let me know in advance so I may decide whether to choose to do that service or not. The initial $55 charge which pays for the time and materials involved in the New Patient Packet is an example of this. I also charge a $100 late cancellation or no-show fee for initial appointments that are not cancelled a week in advance.

My signature below indicates that I understand and agree to all of the above, and that I have called to clarify anything if needed.

_____ _____
Patient Name (print) DOB

_____ _____
Parent/Guardian Signature Date

_____ _____
Adult Patient Signature Date

Initial Clinical Questionnaire

[In this questionnaire "child" refers to kids of all ages, infant to 21 years.]

Child's Name: _____ Age: _____ Gender: [ ] M, [ ] F
Your Name & Relationship: _____ Today's Date: _____
Address: _____
Phone numbers: _____
Primary Care Physician (child's): _____
Therapist (list any from the past year): _____ [ ] current
From whom did you get my name? _____. What is that person's relationship to you? _____
Insurance (Health) Coverage: _____ Through what employer: _____
ID #: _____ Group #: _____
Ethnicity: _____

1. Are there concerns about suicide risk? [ ] no, [ ] yes; explain: _____
_____.
2. Are there concerns about violence toward others (toward whom)? [ ] no, [ ] yes; explain:
_____.
3. Is this assessment needed primarily for a legal matter (e.g., related to a custody decision or a civil suit)? [ ] no, [ ] yes: _____.

[Note: I do not do forensic evaluations.]

3. Does your child have a specific diagnosis (es) for this problem? [ ] no, [ ] yes; explain:
_____.
4. Name all the other diagnoses which have been considered and questioned: _____
_____.
5. Is he/she missing school or work due to this problem? [ ] no, [ ] yes; explain: _____
_____.
6. Are there known or suspected psychotic symptoms (e.g. hallucinations, delusions, or very bizarre behavior)? [ ] no, [ ] yes; explain: _____
_____.
7. Are there concerns about Substance Abuse? [ ] no, [ ] yes; explain: _____
_____.
8. Are there serious current or chronic general health or medical problems? [ ] no, [ ] yes; explain:
_____.
9. Is there a known or suspected developmental delay, intellectual disability ("mental retardation"), or Autism Spectrum Disorder? [ ] no, [ ] yes; explain: _____
_____.
10. Are other agencies involved? [ ] no, [ ] yes:
[ ] IEP at School; [ ] 504 at School; [ ] Juvenile Justice; [ ] County Developmental Disabilities; [ ] Child Protective Services/Child Welfare (DHS); [ ] Other: _____.
11. Is your child currently taking medication for an emotional or behavioral problem? [ ] no, [ ] yes (please **list the daily dosage** for each medication): _____
_____.
12. Has your child had prior intensive treatment? [ ] no, [ ] yes: _____.
[ ] Inpatient; [ ] Residential; [ ] Day Hospital; [ ] Day Treatment; [ ] Other: _____.

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Release of Confidential Information

Patient Name _____ **Birthdate** _____

☒ From Dr. Bingham, to the person or organization named below
☒ To Dr. Bingham, from the person or organization named below
(I recommend checking both boxes if the person or organization is still involved)

_____
Person or Organization

_____

This confidential information may be shared for:
☒ Coordination of treatment
☐ Other: _____

I understand that all records from Dr. Bingham are considered "mental health records." The following types of records may be shared including information about drug and alcohol use.

- Assessments & Summaries
- Visit chart notes
- Laboratory and other test results
- Medication records

I understand that I may revoke this consent at any time, though obviously this would not affect information already released. Unless revoked earlier, Dr. Bingham may release information to the person or organization named here until one year after the file closes with Dr. Bingham. I understand that revocation must be made in writing, addressed to and delivered either to Dr. Bingham in person or by certified mail.

As parent, legal guardian, or adult patient, I authorize the release and exchange of confidential information regarding the patient named above.

_____
Please Print Your Name & Relationship to the Patient

_____
Please Sign Your Name Date