ASSOCIATES IN BEHAVIOR AND CHILD DEVELOPMENT | ABCD, INC., P.S.

DATE:_____

APPOINTMENT REQUEST FORM

Please take a few moments to complete the following appointment request form. The purpose of the information provided is to help us understand your concerns and treatment needs. We will use this to see if there is a specific provider with expertise to work with you or your child. We respond to all requests as quickly as possible, but it may take up to a week in some cases. If we are unable to provide you with services, we will try to provide community referrals but also encourage you to talk with your primary care doctor and/or current mental health provider.

Patient Name: _____ Date of Birth: _____ Age: _____

Parent Name: _____ Parent Name: _____

Parent's relationship to each other: Married→ ☐ Divorced→ ☐ Domestic Partnership→ ☐ Never Married→ ☐

Address: _____

Phone: _____ Email: _____

Patient's School or Employment: _____ Grade: _____

How did you learn about our Clinic/Provider: _____ Name of Primary Care Physician: _____

Name of Insurance Plan: Plan ID #: Group #:

BASIC INSURANCE INFORMATION:

(1) Most of our Clinic's providers are currently **contracted (i.e. "in-network")** with many BUT not all insurance plans associated with *PREMERA BLUECROSS* and *REGENCE BLUESHIELD*

(2) If our Providers are **not contracted (i.e. "out-of-network")** with your specific insurance plan, full payment of each service would be required at the time of each appointment

(3) If one of our Providers is able to schedule with your family member, you will receive an email from accounting@abcdseattle.com (*please check your junk mail*) with general billing and insurance information so that you may **phone** your insurance company directly to find out the **Behavioral/Mental Health** coverage specific to your insurance policy with that ABCD Provider

(4) Dr. Melyssa Higgins is OUT-OF-NETWORK with all insurance companies

(5) Dr. Samuel Wayne Duncan is OUT-OF-NETWORK with REGENCE BLUESHIELD and its affiliates

Which of the following treatments are you looking for:

Diagnostic Assessment	Yes:	☐	No:	☐	Maybe:	☐
Educational Evaluation	Yes:	☐	No:	☐	Maybe:	☐
Psychotherapy	Yes:	☐	No:	☐	Maybe:	☐
Medication Management	Yes:	☐	No:	☐	Maybe:	☐

Is there a specific provider at ABCD that you want to schedule with? Yes: ☐ No: ☐

If YES, which provider: _____

If that provider is not available, would you like to see if there is another provider able to see you or your child: Yes: ☐ No: ☐

Please indicate all concerns below:

☐ ←Attention/ADHD	☐ ←Enuresis/encopresis	☐ ←Eating	☐ ←Aggression
☐ ←Learning/educational	☐ ←Unusual thoughts	☐ ←Anxiety	☐ ←Substance abuse
☐ ←Depression/mood	☐ ←Bipolar disorder	☐ ←Suicide/self-harm behaviors	☐ ←OCD
☐ ←Other (*please explain*)→ _____			

Please provide a brief description below of your concern(s):

_____

_____

_____

_____

_____

Has there been previous treatment with a mental health specialist including psychiatric emergency services or hospitalization? Yes ☐ No ☐

If YES, who did you see and when were you in treatment? _____

OFFICE USE ONLY:

TP	MH	JT	MD	AR	SWD	BN	CM

NOTE: