Samuel W. Sentell, Ph. D. MP

Licensed Medical Neuropsychologist
1513 Line Avenue Suite 127
Shreveport, LA 71101
Phone: 310-675-1515 or 318-868-2001

Declaration of practice

In order to establish clear guidelines and expectations for clients, the following practice guidelines are provided in writing and will be maintained in client files:

1. **Payment is expected at the time of service. Payment can be made with a check or credit card.**
2. **A no-show rate of $50.00 will apply if notification of cancellation is not received prior to 24 hours of scheduled appointments. Regardless if you confirmed with front office.**
3. **If psychological testing is scheduled, fee per test will be supplied upon request. Fees for interpretations of test results as well as written results – reports, if required, will also be provided upon request. Payment is expected at the time of service unless alternate payment arrangements have been made.**
4. **It is the client's responsibility to provide all required information if insurance is to be filed. If we are OUT of Network with a patient's Insurance Company, the client must pay privately at the time of service and upon request, the office will provide the client with appropriate documentation to send to the insurance company for reimbursement to the patient.**
5. **Clients are requested to notify this office as soon as possible in the vent of a change in address or phone number.**
6. **In the event of an emergency, you are requested to call this office to request an appointment ASAP or to go to your nearest local emergency room.**
7. **We do maintain a Cancellation list to assist clients in getting an earlier appointment if possible. However, the cancellation list is NOT a guarantee that a client will obtain an earlier appointment. If an appointment is cancelled, office staff will systematically call down the list sometimes on very short notice and no messages are left. The first person to answer and accept the appointment will obtain that available appointment time**
8. **Phone consultations with Dr. Sentell (including medication management) will be billed at a quarter, half, or full session rate. Invoices for phone consultations will be mailed to the address on record unless alternate mailing arrangements are made. We do NOT bill Insurance companies for phone consultations**
9. **If a written letter or report must be prepared or completed there will be a charge, depending on how in depth the letter/report is. We do NOT bill Insurance companies for letters/reports**
10. **If copies of records are requested for any reason, for any reason, there will be an administrative fee depending on the size of the record: $15 small; $25 medium; $35 large**
11. **We do utilize surveillance cameras in the office (reception window, front and back door) for everyone's safety/protection. No recordings are kept unless a crime was committed during that time of service.**
12. **Dr. Sentell does utilize a camera in the BrainTrain room in order to supervise his patients during treatment. No recordings are kept.**

Medication Policies

It is within the scope of this practice to both prescribe psychotropic medication and provide medication management. Dr. Sentell is required by law to do so in consultation with your primary care physician or another attending physician of your choice. If you do not have a physician, Dr Sentell will assist you to referral sources for local physicians. Policies regarding medications prescribed by Dr. Sentell are as follows:

1. **Patients are required to follow-up with an IN OFFICE appointment at least once every three months if they are prescribed psychotropic medication.**
2. **All prescription renewals must be requested at least seventy-two hours in advance. If requesting a renewal by phone or fax to your local pharmacy or mail order services, please be prepared to provide name, age, type/ dosage of medication, name/phone number of preferred pharmacy**
3. **Please be aware that stimulant medications CANNOT be called in to a pharmacy by phone. There is no charge for phone calls regarding prescriptions renewals at this time, but it is ideal for patients to return to the clinic for a regularly scheduled appointment when refills are needed.**
4. **Adult ADHD and Benzo Groups meet at least once a moth. Patients who are prescribed these medications require minimal participation (once a quarter or every three months). Medication management visits with Dr. Sentell before or after group therapy is a separate service.**
5. **Please call to schedule an appointment or phone consultation if you want to discuss an adjustment in type/dosage or prescribed medication. If you are experiencing significant medication side effects or in the event of an emergency, you are requested to call this office to request an appointment ASAP or go to your nearest local emergency room.**
6. **There are certain medications that Dr. Sentell does not typically prefer to prescribe, although he will provide medication management if these medications were prescribed by a psychiatrist or primary care physician prior to seeking medication management services through the office. For medications with high potential for addiction, such as benzodiazepines, it is Dr. Sentell's policy to prescribe alternative medication with lower addiction potential and all adults who are prescribed these medications will be required to attend Group Therapy!**

WE WILL ASSIT YOU WITH REFERRALS TO OTHER PROVIDERS IF THESE POLICIES ARE NOT SUITABLE FOR YOU.

Client Signature:_____

Date: _____

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As a courtesy, we call and remind patients of their appointment times. We would like to obtain your written permission to do so if you feel comfortable with this. Additionally, please list below the appropriate phone numbers that we may call.

Patient Name _____ Adult___ Child ____
If child. Or disabled adult, name of legal guardian or domiciliary parent
_____

Home Phone _____ _____

Work Phone _____ _____

Cell Phone _____ _____

Other _____ _____

CAN WE LEAVE A MESSAGE? YES / NO (Please circle one)

Signature _____ Date: __ / __ / ____

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LOUISIANA LAW

Louisiana law requires all patients to inform all prescribers about controlled substances being taken. You will be asked to list your medications every visit, please list accordingly and thoroughly.

I understand the above and currently am in compliance with this law.

Signature: _____ Date: _____

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CONSENT TO USE PROTECTED INFORMATION

The attached Notice of Privacy Practices provides information about how I can use and disclose (share) protected health information about you and / or your child. You have the right to review that Notice before signing this consent form. By signing this form, you give your consent for my office to use and disclose protected health information about you / your child in order to obtain authorization for treatment from your insurance company or healthcare plan, to obtain payment for services, or for other mental health operations. If you are not filing insurance, you signature is still required to indicate you have read the Notice of privacy Practices. You have the right to notify me at any time (in writing) that you wish to withdraw the consent cannot be revoked.

You have the right to request restriction on how protected health information about you / your child is used or disclosed for treatment, payment, or mental health operations (see conditions described in the Notice). I am not required to agree with your request but, if I do, then I am bound by that agreement.

The terms and conditions of the Notice of Privacy Practices may change from time to time in order to reflect changes in federal or state laws, or to reflect changes in my office procedures. You may obtain a copy of the current Notice of Privacy Practices by simply asking the office secretary or receptionist.

I give my consent to use protected information.

_____

_____

Signature of Patient, Parent, or Legal Guardian **Date**

I decline to give consent to use protected information.

_____

_____

Signature of Patient, Parent, or Legal Guardian **Date**

_____ **Initials of office staff as witness to decision not to give consent.**

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Licensed Medical Neuropsychologist

Release of Information Consent

I, _____, authorize Dr. S. Webb Sentell to:

(Send / Receive) information regarding _____ to/from the following agencies:

Name: _____ **- Primary Care Physician**
Address: _____ City _____, State ___ Zip _____

Name: _____
Address: _____ City_____, State ___ Zip_____

Name:_____
Address:_____ City_____, State___ Zip _____

____ Academic Testing Results
____ Behavior Programs
____ Case Notes
____ Intelligence Testing Results
____ Medical Reports
____ Personality Profiles
____ Progress Reports
____ Psychological Reports
____ Psychological Testing Results
____ Service Plans
____ Summary Reports
____ Vocational Testing Results
____ Entire Record
____ Other (specify) _____
_____
_____

The above information will be used for the following purposes:

____ Planning
____ Case Review
____ Other (specify)
____ Continuing appropriate treatment or program
____ Updating Files
____ Updating Files

I understand that I may revoke this consent at any time by providing written notice. I have been informed what information will be given, the purpose, and who will receive the information.

Client's Signature:_____ Date:___/___/_____
Parent/Guardian Signature:_____ Date:___/___/_____

REGISTRATION FORM

Today's Date:	Provider:

PATIENT INFORMATION

Patient's last name: Patient's first name:	Middle:	Marital status:	

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:		Sex: ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and driver's license to the receptionist to copy for records)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber:					

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Staff Verifying Client Information

Name _____ Date _____

S.WEBB SENTELL, PhD, MP
CLINICAL INTAKE

Form filled out by _____ Relationship _____ Date _____

Name of Patient _____ Insurance _____

Patient's Age _____ Birth Date _____ SSN _____

Phone _____ Address _____

Referred by _____

1. **What is your main problem? (Use back of form as needed)**

2. **Do you have other problems? If yes, list them**

3. **List your medications.**

(a) Do you have any known allergies to medications, etc.?

4. **Have you ever been hospitalized? When? Where? What for?**

   (a) Have you been treated for mental or nerve problems as an outpatient? Who treated you? When were you treated?

   (b) Have you ever been hospitalized for suicide attempt? Yes ____ No ____
   If yes, explain when and where.

5. **Have you ever been knocked out? How old where you? How long where you out?**

6. **Were you ever in a car wreck? Were you hospitalized? How long?**

7. **Have you had seizures ever? How many? How often?**

8. **If this is a child… how old was he / she when:**

   First walked _____
   First talked _____
   Potty-trained _____

9. **How much alcohol and/or street drugs do you use now? In the past?**

10. **Were you ever in drug or alcohol treatment? When? Where? AA or NA etc.?**

11. **Who do you live with? Marital history? Children?**

12. **Does anyone in your family have problems like you?**

13. **Other family problems?**

14. **How far did you go in school? Where?**

15. **Military service? Discharge? Combat Vet?**

16. **What was your longest job? What was your last job? Ever fired? What for?**

17. **Daily activities?**

18. **Do you work? Where and how long etc.? What keeps you from working?**

19. **(if child) what keeps him/her from being like others his/her age?**

20. **Do you have any known allergies to medications etc.?**

21. **Do you have a legal or child abuse case pending? Dr. Sentell does not take legal or child abuse cases or any action that may be involved in court action.**

LAST TWO PAGES TO BE COMPLETED BY CLIENT _____

1. **Do you see or hear things that other people don't? If yes, describe.**

2. **Do you feel that ideas are put in your head or taken out? (Like getting personal messages from TV or mind reading, etc.)**

3. **Is something or somebody out to get you or do you feel unsafe or scared?**

4. **How do you feel most of the time?**

Happy	**Angry**	**Hyper**	**Irritated**
SadScared	**Nervous**	**On top of the world**	
Normal	**Blue**	**Sleepy**	**Depressed**

5. **How do you sleep?**

6. **How is your appetite?**

7. **How is your energy?**

8. **Do you feel like harming yourself now or in the past? If yes, give details**

9. **Do you feel like harming others now or in the past? If yes, give details**

10. **Have you ever acted on ideas about hurting yourself now or in the past? If yes, give details.**

11. **Do you have any other symptoms or nervous problems?**

PLEASE DO YOUR OWN WORK ON THESE

When did you eat last?

What did you eat last?

When did you watch TV last?

What did you watch on TV last?

What did you get for Christmas?

A. Remember these 4 words: Key Nail Quarter Rabbit's foot

B. Answer these:

3 + 4 =	**9 + 6 =**	**20 – 11 =**	**100 – 50 =**
2 x 2 =	**25 – 5 =**	**100 – 2 =**	**7 x 5 =**

C. What does this saying mean? "The early bird gets the worm."

D. What would you were lost in the woods in the daytime?

E. What is the opposite of: up _____ big _____ quiet _____ liberty _____

F. What would you do if you were in a theatre and saw smoke or fire?

G. If you had one wish… What would you wish for?

H. On the back, draw (1) a triangle (2) a flower in a flower pot (3) a clock reading eleven-ten (11:10)