Eating Disorders Associates
Phone (310) 325-4353 • Fax (310) 325-5732 • mail@DrSchack.com
www.EatingDisordersAssociates.com
Linda Schack, M.D. • Bobbi O'Brien, Ph.D. • Jennifer Kromberg, Psy.D. • Elizabeth Katcher, Ph.D., P.A.

MEDICAL STABILIZATION PROGRAM

In order to schedule your admission appointment, please complete all included documents.
The checklist below has been provided to assist you.
Fax to (310) 325-5732 or scan and email to mail@DrSchack.com

☐ Patient Information Sheet *(to be completed by financially responsible party)*, pages 2, 3.

☐ Confidentiality Agreement *(to be completed by patient; if under 18, parent signature required),* page 4.

☐ Patient Treatment Agreement *(to be completed by patient and parent),* page 5.

☐ Communication Preferences *(to be completed by patients over 18),* page 6.

☐ Current Treatment Professionals, page 7.

☐ Nutritional Supplements and Testing Information *(to be completed by financially responsible party),* page 8.

☐ Essay Questions (*to be completed by patient*) , page 9.

☐ Copy of front and back of medical insurance card.

☐ Copy of Arbitration Agreement *(to be completed by responsible party upon admission).*

Before returning, please double-check that you have filled out the admission packet as completely as possible. Incomplete information will delay the admission process.

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PATIENT INFORMATION

Please print clearly.

Date ________________

Patient Name ____
Last *First* *Middle Initial*

Birthdate ____ /____ /_______ Marital Status ____________ email ______________________________

Occupation ____ SSN ________-_______-__________

Home address ____

City, State Zip ____

Home Phone (_____) ___________________________ Mobile (_____) ____________________________

RESPONSIBLE PARTY

Person financially responsible for treatment.

Responsible Party Name ____ Birthdate ___/___/______
Last *First* *Middle Initial*

Email_________________________ Relationship to Patient _____________________________________

Occupation ____ SSN ________-______-_________

Home address ____

City, State Zip ____

Home Phone (_____) ____________________________ Mobile (_____) ___________________________

EMPLOYMENT

☐ *Patient* *or* ☐ *Responsible Party*

Employer _______________________________________ Job Title:_______________________________

Business address ____

City, State Zip ____

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SIGNIFICANT OTHER

☐ *Second Parent* ☐ *Spouse* ☐ *Domestic Partner*

Name ____ email ______________________
Last *First* *Middle Initial*

Birthdate _____ / _____ / _________ Relationship to Patient ________________________________

Occupation ____ SSN _________-_______-_________

Home address ____

City, State Zip ____

Home Phone (_____) ________________________ Mobile (_____) _________________________

EMERGENCY CONTACT

Primary Care Physician ____

Phone (_____) _______________________ Fax (_____) _______________________

Emergency Contact Name:____

Relationship ___________________________

Home Phone (_____) ________________________ Mobile (_____) _________________________

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CONFIDENTIALITY AGREEMENT

To be completed by patient.
If patient is under 18, to be completed by patient and parent.

I understand that Drs. O'Brien, Schack, and Kromberg and Katcher will maintain confidentiality, except in the following circumstances:

1. I am threatening physical harm to myself or another.
2. Receipt of a court order mandating information.
3. I am found to be involved in the abuse of a minor, dependent adult, or elder.
4. I have given written consent to release information to a specified party.
5. Drs. O'Brien, Schack, Kromberg and Katcher will communicate with each other, and with treatment professionals directly involved in my care, as needed.

I understand that Bobbi O'Brien, Ph.D. is a clinical psychologist, CA License PSY 18147.

I understand that Jennifer Kromberg, Psy.D. is a clinical psychologist, CA License PSY 17691.

I understand that Linda E. Schack, M.D. is an adolescent medicine specialist, certified by the American Board of Pediatrics Subboard of Adolescent Medicine.

I understand that Elizabeth Katcher, Ph.D. Is a Psychological Assistant, CA Registration PSB94021181, supervised by Bobbi O'Brien, Ph.D.

More biographical information is available at www.EatingDisordersAssociates.com.

I understand that information will be provided to me by Drs. O'Brien, Schack, Kromberg and Katcher regarding evaluation and treatment, including goals, risks, and benefits of treatment and that I will have the opportunity to discuss this and to ask any questions needed to clarify my understanding.

____ ____________________
Name of patient (please print) *Date*

____ ____________________
Signature of patient *Date*

____ ____________________
Signature of parent or legal guardian if patient is under 18 *Date*

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PATIENT TREATMENT AGREEMENT

Patient to Complete and initial items 1-8.
Parent(s) to initial item 8.
For patients under 18, parent to co-sign at bottom.

I, __________________________, agree to comply with all recommended treatment. Specifically, I agree to:
Patient's name

________ 1. Have a complete physical examination.

________ 2. Consume recommended food calories daily, by eating all of presented meals or any portion of meals plus an amount of liquid supplement calorically equivalent to the uneaten portion.

________ 3. Take recommended medications.

________ 4. Allow laboratory testing as ordered.

________ 5. Participate in psychotherapy sessions.

________ 6. Comply with program requirements. *(For more information see Frequently Asked Questions included in this packet.)*

________ 7. I understand that unhealthy behaviors are not permitted, including cigarette smoking.

________ 8. Parent(s), caregivers, or significant other(s) agree to attend a minimum of two sessions of family education/support, once per week.

____ ______________________
Signature of patient *Date*

____ ______________________
Signature of parent or legal guardian if patient under 18 *Date*

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COMMUNICATION PREFERENCES

All patients 18 and older must complete.

I, ___________________________________ give permission for Drs. Schack, O'Brien, Kromberg and Katcher to communicate with the following people regarding the treatment of my eating disorder for the duration of my medical hospitalization *(it is strongly recommended that both parents be listed if both are living and in contact with you)*. Please also list at least one parent or other adult close friend, partner, or relative:

____ ________________________________
Name *Relationship*

(________)__________________________ (________)__________________________________
Phone *Alternate phone* ☐ *Home* *or* ☐ *Mobile*

____ ________________________________
Name *Relationship*

(________)__________________________ (________)__________________________________
Phone *Alternate phone* ☐ *Home* *or* ☐ *Mobile*

____ ________________________________
Name *Relationship*

(________)__________________________ (________)__________________________________
Phone *Alternate phone* ☐ *Home* *or* ☐ *Mobile*

____ ____________________________
Signature of Patient *Date*

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CURRENT TREATMENT PROFESSIONALS

To be completed by patient and/or parent.

Referring Institution (if applicable) ______________________________

Name of Program ______________________________

Program Director ______________________________

Phone ____________________ Fax ____________________

Please list all health professionals currently involved in the treatment of your eating disorder:

Primary Care Physician______________________________

Phone____________________ Fax____________________

Primary Therapist ______________________________

Phone____________________ Fax____________________

Dietitian______________________________

Phone____________________ Fax____________________

Psychiatrist ______________________________

Phone____________________ Fax____________________

Other *(family therapist, athletic trainer, alternative medicine provider, etc.)*

Name____________________ Specialty ____________________

Phone____________________ Fax____________________

Name____________________ Specialty ____________________

Phone____________________ Fax____________________

Name____________________ Specialty ____________________

Phone____________________ Fax____________________

I agree to the release of information between the Torrance Memorial Medical Stabilization Program professionals and my previous treatment professionals.

Patient signature______________________________ Date____________________

Date of Birth____________________

Parent Signature ______________________________ Date____________________

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FEES

Program Fee

There is a non-refundable program fee of $650, which will be due prior to admission (covers materials, administration and outside professional consultation). If the hospitalization extends beyond 2 weeks, there will be an additional program fee of $300 per week, charged to your credit card, unless other arrangements are made.

Insurance

Dr. Schack is an out of network provider. Her office bills your insurance company as a courtesy. If you receive a reimbursement check for Dr. Schack's portion of your hospitalization, we appreciate you promptly sending us a check for the same amount. Dr. Schack will accept this amount as payment in full for her services provided during your hospitalization.

Micronutrient Testing

Micronutrient testing is also recommended in order to identify specific deficiencies and target supplementation to your needs. We use Spectracell Labs for our testing, and they require a co-pay to be sent along with your specimen. The co-pay is $190 for most insurance carriers. This will be charged to your credit card by Spectracell. If your insurance is not contracted with Spectracell, the fee is $290.

Nutritional Supplements and Testing Information *To be completed by financially responsible party.*

Most patients who are admitted for medical stabilization related to an eating disorder benefit from nutritional supplementation. The choice of supplements is individualized; examples of frequently used supplements include fish oil, calcium, potassium, magnesium, phosphorus, multivitamins, vitamin B-12, B-complex, and probiotics (beneficial bacteria used to improve intestinal health).

Our hospital formulary is somewhat limited in this area. Therefore, our practice is to stock our own supplements and provide them when there is no equivalent hospital formulary product. We have most supplements on hand and can provide them to patients immediately. No sales tax is collected since physician-provided supplements are considered medical treatment.

Patients will be billed for supplements at the suggested retail price. Alternatively, you have the option of sourcing and purchasing your own supplements (we will provide you or a designated family member with a list of recommended products).

Please indicate your preference below:

σ I am providing my credit card information to cover the $650 program fee, the $190 (or $290) micronutrient testing, and recommended supplements.

σ I am providing my credit card information to cover the $650 program fee and the $190 (or $290) micronutrient testing. I would like Dr. Schack to provide a list of recommended supplements to me and I will source and purchase them myself.

☐ Visa ☐ MC ☐ Disc ☐ Amex Name on card____

Card #____ Security code__________ Exp. date __________

Billing address ____

City, State Zip ____

Signature_________________________________ Printed name_____________________________

If you are registered for our program and subsequently cancel your admission plans, your program fee will be returned less $100.

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Please answer the following questions *as comprehensively as possible*, so that we can best help you.
(for the patient)

Why have you decided to seek help at this time?

What made you choose TMMC Medical Stabilization Program, as opposed to other treatment programs?

What are your goals for this hospital stay?

Please summarize any previous treatment you have received for your eating disorder.

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FREQUENTLY ASKED QUESTIONS

For patient and financially responsible party.

How long will I have to stay in the hospital?

Patients stay in the hospital until they are medically stable. For a few patients this will take several days. Most patients with orthostatic hypotension (unstable pulse and/or blood pressure) and patients with bradycardia (slow heart rate) can expect to stay two to three weeks, as these conditions generally take a long time to improve.

We do not have a discharge "weight goal" for underweight patients, except in cases of extremely low weight. If a patient is underweight, they may be discharged when they are gaining 1-3 lbs./week, medically stable, and obtaining 100 percent of calories by eating meals (no supplement use). Some patients may be able to leave the hospital earlier if accepted for direct transfer by a residential eating disorders treatment program.

Why do I have to get up out of bed during meals?

Even though you are in the hospital, it is important for your recovery to remain as functional as possible. People tend to feel more helpless and tired if they stay in bed all the time. Meals are an active, important part of your recovery, and it is helpful to be alert and aware of your reactions to the process of eating.

Why can't we bring food from home?

We understand that your teen or young adult would prefer a good home-cooked meal over hospital food. Similarly, it is natural for parents to want to feed their children. However, in order for the recovery process to begin, patients need to use the services provided by the treatment team, including food. Dietary staff is also better able to assess eating patterns when there is a continual working relationship with the patient, which includes meal planning, education, and consumption of food provided. Later on, when your son or daughter can consistently eat the meals provided by the dietary staff, you will be able to bring some meals and snacks to be incorporated into the treatment.

Why can't parent(s) stay during the meal?

Meals are a very important part of the treatment (we view them as a medical intervention) and require monitoring by the nursing staff. Your teen or young adult needs to begin to trust the staff during meals, which is more difficult if parents are present. Similarly, patients may be self-conscious about eating in front of friends and family. Meals with family members can be planned further into the treatment process.

If all we're doing is having our daughter eat regular food, why can't we do that at home? I'm a nurse and can check her blood pressure and pulse.

The hospital is providing much more than food. If your daughter had been able to eat at home, she would not need to be in the hospital. Eating disorders are very complicated. Round-the-clock observation enables us to see facets of the eating disorder that may be otherwise hidden, and begin to address them in treatment. Accurate and continual measurements of body weight, fluid intake, urine output, and calories consumed also enable the physician and dietitian to assess calorie needs much more accurately. The hospital is also the safest place for your daughter to be right now.

Many patients feel relief when they enter the hospital, because the constant internal dilemma that they have about which foods to choose and/or eat are removed. In addition, the power struggles which sometimes ensue at home, with parents trying to get their son or daughter to eat or prevent them from purging are not present in the hospital.

It is important to allow yourself room to be a parent, and it is asking too much of a parent to also provide medical treatment for their child. It is also confusing for adolescents and their parents when parents act as medical providers.

Why do the nurses have to search my belongings?

Eating disorders sometimes lead to behaviors you otherwise would not engage in. Going into the hospital is a big step, and it can be difficult to give up the use of artificial sweeteners, laxatives, or other substances when you may not feel ready. Sometimes items are also inadvertently brought in by visitors. However, having these things in your room could interfere with your recovery and/or pose a threat to your safety.

Why can't I be told the weight?

People with eating disorders tend to over-focus on their weight and body appearance, and it is easy for significant others to get pulled into this. We know you are concerned about your child's health, which may be threatened by an unhealthy body weight. However, we recommend that parents stay out of weight discussions which can trigger arguments, comments and dynamics that impede recovery. The easiest way to avoid this problem is to have no knowledge of the scale number. We also want to avoid situations in which a parent has information that the patient is not allowed to have, which can erode trust. In most cases, the physician will review weights periodically (every 5-7 days) with the patient.

Why can't parent(s) stay in the hospital overnight?

Adolescents need space to begin to trust the treatment team, which is more difficult if parents are always available to meet their needs. Teens are also better able to experience their emotions when they have some time alone. This is very important in the recovery process.

Nursing staff are always available to patients if they need something, or if they are having a hard time. Parents also need an opportunity to get adequate rest and to get in touch with their own reactions to what is happening in the family. Parents who are well-rested and allow time for themselves are better able to provide support for their adolescent.

What should I bring with me?

We recommend that you bring a bathrobe, slippers, and two or three sets of pajamas. You also need to pack a seven- to 10-day supply of comfortable clothing to wear during the day (shorts, jeans, sweat pants, T-shirts, socks, tennis shoes, etc.) Bring a light jacket or sweatshirt as you may be able to spend some time outdoors when your condition improves. We do not have laundry facilities, so please arrange for someone to take your laundry home and bring you fresh clothing at regular intervals. Bring whatever toiletry items you'd like, or we can provide you with basics such as shampoo and toothpaste.

If you like, you are welcome to bring your own pillow and blanket or comforter. Items for decorating your room, such as framed photographs, posters, and artwork are fine. You may also bring a cell phone and laptop computer; Torrance Memorial Medical Center has free Wi-Fi available. Some other items you might like to have with you are DVD movies, books, a journal or art paper, crossword or jigsaw puzzles, and a music player.