Optimal Behavioral Health, LLC
11160 Highway 62, Suite B
Eagle Point, OR 97524
(541) 826-0899
Fax (541) 826-2234
www.optimalbehavioralhealth.com

PROVIDER-PATIENT SERVICES AGREEMENT

INTRODUCTION:
Welcome and thank you for scheduling an appointment. This document contains important information about your provider's professional services and business policies. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign this document or at any time in the future.

OFFICE HOURS:
Office hours are by appointment Monday through Thursday. **The office is not open on Fridays.** The front office is open Monday through Thursday from 8:30 a.m. through 5:00 p.m. If you need to contact the office regarding an appointment, billing questions, or for general needs, please call (541) 826-0899 during these hours. We are a small office with only 1 support staff and may not always have availability to answer the phone when you call. We would ask you to please leave a message on our voicemail and understand that we will do our best to respond to your message at the next available opportunity. After office hours, messages may be left with our answering service. The office is closed for all major holidays and may be closed at times for vacations. Closure dates are posted on our website.

CONTACTING YOUR PROVIDER:
Your questions or concerns about diagnoses, treatment, medications, and therapeutic interventions are all an important part of our work together. We would like to address these with our undivided attention and can best do so during our face-to-face, scheduled appointment time. If you have **non-emergency or routine** questions between appointments, please write them down and bring them to your next appointment. **Please do not text these questions.**

Medication changes will not be made between appointments unless previously agreed upon between you and your provider.

If there is an **urgent** matter, such as a side effect to a medication, please call the office between 8:30 a.m. and 5:00 p.m. You may leave a message and your provider will call you back at the next available opportunity. If it is after-hours, please leave the message with our answering service.

For all life-threatening emergencies, such as an overdose of medication, seizure, plan for violence/homicide, suicide attempt/plan, etc., or if an urgent situation turns emergent, **please call 911 or proceed to the nearest hospital emergency room**. Please give our contact information to Emergency Department staff so they can contact us and we can coordinate your care.

TELEPHONE CONTACT FEES:
We may charge you a fee for telephone calls relating to your care, with charges based upon the amount of time spent and the complexity of the call. We charge a minimum of $25.00 for ***non-urgent after-hours*** telephone calls, and additional charges may be incurred.

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APPOINTMENT REMINDERS:
As a courtesy, a reminder for your next appointment date/time will be sent by texspecify otherwisePlease realize that you are responsible for the appointments that you schedule.

CANCELLATIONS:
Appointments are scheduled individually. Except for unforeseen emergencies, **notification of cancellation is expected 48 business hours in advance.** For example, an appointment for Monday needs to be cancelled before the close of business Thursday to avoid a missed appointment charge. If you do not give 48 hour-advanced notice, you will be charged for the missed session at $225.00. Insurance companies do not provide reimbursement for no-show appointments and/or appointments cancelled without sufficient notice. 48-hours allows us time to fill the cancelled appointment slot with patients who are on the waiting list. This improves access to care for all patients served in our clinic. **Please do not cancel appointments by text.** Please phone the office at (541) 826-0899 to cancel and/or reschedule your appointment.

LATE POLICY:
Please arrive on time for your appointment. Patients arriving more than 10 minutes late may be asked to reschedule. Please keep in mind that our next available appointment time is often >4 weeks out. This means if your appointment must be rescheduled, it may be several weeks before you are seen.

MEDICATION REFILLS:
Refill requests need to be called in to the office ***at least 3 to 5 business days*** in advance of the date they are needed. It is your responsibility to contact the office before you run out of medications. Please have your pharmacy **fax refill requests to (541) 826-2234**. Refills will only be written or faxed Monday through Thursday as providers are out of the office on Fridays. Refill requests will not be addressed after-hours or by the on-call provider. The office is closed for most holidays. Closure dates are posted on our website. Please plan your refills accordingly.

Refill requests for stimulant medications (Ritalin, Adderall, Vyvanse, Metadate, Concerta, etc.) need to be made directly to our office (not the pharmacy). Stimulant prescriptions expire 21 days from the date they are written unless the provider has written a specific date for the prescription to be filled. If your prescription expires before you take it to the pharmacy or if you lose your stimulant prescription, you will need to contact the office to request a new prescription. There is a $10.00 fee to rewrite any expired or lost prescriptions. Please be aware that stimulant prescriptions require appointments with your provider on a monthly basis

We require that patients on psychiatric medication be seen at least once every 90 days. If a patient has not been seen in the office in the last 90 days, we will not issue a refill without a scheduled follow-up appointment. If an appointment is scheduled, we will provide a refill of medication for the duration needed until that appointment. unless your provider agrees otherwise.

ELECTRONIC MAIL (EMAIL) POLICY:
We appreciate that you may want to send information via email. However, because of the volume of patients we see, this is not a preferred form of communication as your provider may not have time to either read and/or respond to your email. Therefore, urgent or emergent matters should never be sent by email. Additionally, unless email is conducted through a secure server, confidentiality cannot be ensured. If you do communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). Due to this intrinsic vulnerability, we will save email correspondence with you and these communications should be considered part of the medical

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record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart.

PATIENT PORTAL:
A Patient Portal will be setup for you when you are scheduled for your first appointment with a provider in our practice, or if you are an existing patient. This portal will allow you to see any upcoming schedule appointments, make changes to your demographic information, make changes to your insurance information, view/download practice documents/paperwork, access billing statements, change your password and/or security questions, view our office location, and respond to any secure messages your provider may have sent you. **Two days prior to your next appointment**, you will receive an email prompting you to login to your Patient Portal and complete paperwork in the privacy of your home instead of at our office. If you do not have Internet access, **please arrive 15 minutes early to your scheduled appointment** so you can complete paperwork prior to your appointment. **You cannot cancel or schedule appointments through the Patient Portal.** This must be done by phoning the office at (541) 826-0899.

FORMS AND LETTERS:
Any additional paperwork, letters, or forms not specifically related to intra-office care will be subject to a fee based upon the time it takes to complete the documentation ($25 for 5-15 minutes, $50 for 16-30 minutes, $75 for 31-45 minutes, etc.) which will need to be paid prior to the release of the paperwork.

TERMINATION OF TREATMENT:
Patients are not obligated to continue treatment. If you decide to terminate treatment at any time, you are encouraged to discuss your decision to terminate care with your provider. Your provider will work with you to ensure a smooth transition of care.

Regular attendance at scheduled appointments and adherence to treatment recommendations is important for reducing symptoms, enhancing cost-effectiveness of treatment, and optimizing potential for increased quality of life. If you have several missed, cancelled, or no-show appointments, your provider may notify you that your treatment will need to be transferred to your primary care provider, the local county mental health agency, or to another psychiatric provider. If a Release of Information has been signed, a copy of records will be forwarded to the provider and/or agency to whom your care is being transferred. You will also be provided with a 30-day supply of medications currently prescribed by your provider to assist with transition of care.

INSURANCE AND PAYMENT INFORMATION:
Our providers are credentialed (in-network) with several major health insurance companies, although they may not necessarily be credentialed (in-network) with your insurance company. ***Our providers are not credentialed with OHP or Medicare.*** If you have a health insurance policy, we can provide you with assistance in helping you receive your benefits. Please be aware that your insurance contract is between you and your insurance company and please note that **you,** not your insurance company, **are responsible for full payment of any fees incurred.** It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions about the coverage, we recommend you call your plan administrator. You will be responsible to know the terms and exclusions in your insurance policy, and to ensure your insurance carrier's cooperation with us. If our providers are out-of-network with your insurance company, you will be responsible for paying any balance not covered by your insurance. A cash discount is offered for patients who wish to be seen on a cash-only basis. A separate Fee Agreement will need to be signed.

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Patients with insurance coverage are expected to pay their co-pay to **Optimal Behavioral Health** at each appointment, as well as all fees not covered for any reason. Patients with a coinsurance will be billed after each appointment. Payment is expected at the time of service and may be made by cash, check, or credit card (Visa, MasterCard, Discover, American Express). Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee. If no insurance payment has been received within 60 days of billing, you will be responsible for paying the unpaid balance on your account. If we subsequently receive payment from the insurance company, you will be promptly reimbursed.

Optimal Behavioral Health has a legal right to utilize a collection or billing service to collect payment in full for services rendered if there is a failure by the patient to pay any unpaid balances. We may impose an additional 43% fee if the account is referred for regular collection. We may impose an additional 68% fee if the account is referred for legal collection.
Your contract with your health insurance company requires that we provide the health insurance company information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. In some cases, the insurance companies may share clinical information with a national medical information databank. We can provide you with a copy of any report we submit, at your request. By signing this Agreement, you agree that we can provide requested information to your insurance carrier.

CONSENT TO TREATMENT AND PATIENT/GUARANTOR PAYMENT RESPONSIBILITY:
I have read the policies listed above and I understand and agree to them. I or __________________ (patient name) agree to be treated by either Melanie Kabot-Sturos, PMHNP-BC, MSN or Curt Sturos, MD and, when necessary, any provider covering in their absence. I agree that I am responsible for all charges for services rendered and I agree to adhere to the payment policies.

I hereby authorize my individual provider to release to my insurance company all information they may require concerning patient care.

Your signature below indicates that you have read this Provider-Patient Services Agreement and agree to the terms contained in this document.

______________________________	______________________________	__________
Patient Name (print)	**Signature**	**Date**

<u>If patient is a minor or has a guardian:</u>

______________________________	______________________________	__________
Parent/Guardian Name (print)	**Signature**	**Date**

Patient Information:

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______________________ ____ ______________________ ______________
Patient First Name **MI** **Last Name** **Date of Birth**

______________________ ______________ ______ ______________
Address **City** **State** **Zip**

______________________ ______________________________________
Contact Phone **Email address**

Guarantor Information (complete only if the patient is NOT paying for the bill):

______________________ ____ ______________________ ______________
Guarantor First Name **MI** **Last Name** **Date of Birth**

______________________ ______________ ______ ______________
Address **City** **State** **Zip**

______________________ ______________________________________
Contact Phone **Email address**

Credit/Debit Card Payment for Professional Services

_______ Visa _______ MasterCard _______ Discover _______ American Express

Name as it appears on Card: ______________________ Billing Zip Code: ______________

Credit/Debit Card #: ______________________________ Exp. Date: ______________

I/we authorize Optimal Behavioral Health to bill the above credit/debit card for professional services at the time of service provided for ______________________ (patient name). I/we will notify Optimal Behavioral Health in writing if I/we no longer want this credit/debit card billed.

______________________________________ ______________________
Signature of Cardholder Date

Credit/Debit Card Payment for missed or cancelled appointments with <48-hours advanced notice:

I authorize Optimal Behavioral Health to charge the above credit/debit card when at least 48-hour advanced notice is not given for appointment cancellations by ______________________ (patient name). I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

______________________________________ ______________________
Signature of Cardholder Date

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