Office Policies and Payment for Services

Appointments Therapy and consultation appointments are 50 minutes long. Your appointment time is held exclusively for you. Please arrive on time as you use your own time when you are late. If you are going to be unable to keep an appointment, you are asked to provide one full business day (no less than 24 hours) notice or you will be charged for the time as though you attended. Please note that insurance companies will not cover this charge and you will have to pay the entire amount out of pocket.

Office Hours and Emergencies I share this suite of offices with a number of other mental health practitioners. Each of us is in independent practice. We have no responsibility for each other's businesses or patients. My office hours are Monday through Friday 9:00am – 6:00pm. To reach me during those hours call (503) 284-2899 and I will call you back as soon as possible. If you call outside office hours, leave a message and your call will be returned the following business day. If your call is urgent, follow the directions on the voice-mail. If you need immediate support before I call, please go to the emergency room of your nearest hospital. When I am out of town, another practitioner will be available for emergencies.

Confidentiality and the Release of Information Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: 1) Cases of suspected abuse or neglect of a child, 2) Cases where I believe the client presents a clear and imminent danger to him/herself or to another person, 3) Cases where a court subpoenas me to testify or subpoenas my records, 4) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment.

HIPAA Notice of Policies and Practices I am committed to preserving the privacy of your personal health information. Additionally, I am required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (1) how clinical information about you may be used and disclosed and (2) how you can get access to this information. Please ask for a copy of the *HIPAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

Fees The fee for therapy, consultation, and mediation services is **$200.00 for the first session** and **$150.00 for fifty minute sessions thereafter**. **Parent Coordination services are charged at $175.00 per hour**. Shorter or longer appointments will be pro-rated at that same rate. You will also be charged this same rate for additional services provided at your request or for your benefit (at the request of an insurance company, attorney, etc.) such as report writing, psychological test scoring, consultation with other professionals, hospital visits, and phone calls over ten minutes with you or others. **Any legal or court work will be charged at $300.00 per hour**. Payment in full is expected at the time of the visit unless my contract with your insurer prohibits collecting in full. This is also true for child clients, regardless of who brings the child to the visit, or if the child comes unescorted by an adult. For your convenience, I accept VISA, MasterCard, or debit card.

Responsible Party We will send the monthly billing statement to one household or one responsible party only. If two or more people from different households share financial responsibility for a client's medical expenses, we will bill only one of them, the one who signed the intake forms accepting financial responsibility. If someone other than that person wishes to be the responsible party, he or she can fill out and sign intake forms, after which responsibility for the account can be transferred.

Insurance We will bill your insurance company monthly as a courtesy to you and will follow up with them to assist in getting reimbursement for services. However, you are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Am I a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for the entire bill whether the insurance pays or not.

Billing I will use a billing service to prepare your bill and track your account. Please refer any questions you may have about your bill to Crystal Billing (360-260-9799). We bill monthly at the end of our billing cycle which ends on the 15th. If, for any reason, you have a personal balance on your account, I will expect payment no later than the last day of the billing cycle. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

- Unless you have BlueCrossBlueShield, **payment in full is due at the beginning of each visit.** If this is prohibitive for you, please speak with me right away to see if something can be worked out.
- I do not require a retainer for Parent Coordination services, but I do require that you leave a credit card or debit card on file.
- Note: Insurance companies generally will *not* cover parent coordination, mediation and most parent consultation services

Print your Name _____

Signature _____ **Date** _____

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Office Policies and Payment for Services

❑ I have BlueCrossBlueShield and will use the following to pay my copays and deductable:
- ❑ Check
- ❑ Credit Card

Please contact BlueCrossBlueshield or my billing agency. They will tell you the correct copay/deductible amount to pay at each visit.

❑ I have insurance *other than* BlueCrossBlueShield and will pay my balance in full each session with the following: ❑ Check
❑ Credit Card

You will be reimbursed when we receive reimbursement from your insurance company.

❑ I do not have insurance, or services are not covered, and will pay my balance in full each session with the following: ❑ Check
❑ Credit Card

Credit /Debit Card Information

Even if you plan to pay by some other method at each visit, I still require your credit or debit card information to insure prompt payment. If you do not pay the full amount you owe at each visit, your credit/debit card will automatically be charged for the entire amount you owe.

Debit Card ☐ Credit Card ☐
VISA ☐ MasterCard ☐ Discover ☐

Name on the Card _____
Billing Address for Card Holder
_____
_____
_____

Card # _____ Expiration Date _____

Security Code (last 3 digits on back of your card) _____

My billing service can automatically charge your credit/debit card to pay any balance on your account as charges are incurred. OR, if you prefer, they will charge your card only when you do not pay at the time of service. Please choose one of the options below:
☐ Use my card to automatically pay all charges I owe as they are incurred.
☐ I plan to pay my balance in full at each visit by check cash or money order. Use my card only to automatically pay any balance I owe when I do not pay at the time of service.
I authorize payment for the following patient(s): _____
_____
Your Signature _____ Date_____
Print Your Name _____