POLICY STATEMENT

Confidentiality: Your participation and treatment, information about you and anything discussed between us will be kept confidential and will not be shared without your written consent. The following are a few exceptions to this policy: a) If there is a threat of harm to you or another person, b) If there is a suspicion of child and/or elder abuse, c) If I receive a court subpoena to testify or relinquish records, d) During an emergency situation when you are unable to give written or verbal consent but clinical information is needed to make a decision, e) When required for billing by insurance companies (in this case only the minimum information that is required will be provided and if more is requested, I will inform you first.) In order to further ensure your privacy, please remember that e-mail and phone communications are not secure.

Emergencies: My regular office hours are Monday to Wednesday from 10:00 a.m. to 5:00 p.m. I don't carry a pager. You may leave a voice message for me at 503-754-3050 any time. Generally, non-urgent calls are returned within 2 business days. If I am away for any period of time, my voice message will refer you to a trusted colleague who will provide care for my clients while I am away.

In the event of an emergency, call 911, or go to the nearest emergency department. Or call the Mental Health Crisis line at: 503-988-4888, or 1-800-716-9769.

Prescription Refills: Refills for medications are written at the time of the appointment. Please ensure you attend appointments to receive them. Refills are not considered an emergency and requests by phone should be infrequent. Please allow a week for a refill request. Controlled substances are refilled in person at your scheduled appointment.

E-Mail Privacy Policy: Please note that email is not a secure form of communication. My e-mail is not an encrypted email account, any information you send is not secure, sending of information to this account is at your own risk. I am prohibited from corresponding with or about patients other than via the "confidential email address" that you provide me with. If you are uncomfortable with the use of email for clinical or treatment purposes, or if you do not check your email frequently, please let me know.

Inclement Weather Policy: In the event of snow, ice or other inclement weather conditions, my office will follow Portland Public Schools. If they are closed for the day, we can have our appointment via the telephone or Skype at our usual time.

Termination of Treatment: Please let me know if you are considering terminating treatment. If you have not scheduled an appointment for a period of 60 days and have made no prior arrangements with me, you may no longer be considered in active treatment. If you "no show" or "late cancel" for one appointment without rescheduling in 30 days, or you are otherwise not engaged in treatment, you will be considered to have terminated treatment. I will also consider terminating care after the third "no show." When treatment is terminated for any reason and you wish to re-engage treatment, we can discuss it at that time.

Payment: I will bill all insurance companies as a courtesy. Payment in full (or copay/coinsurance) is due at the time of service. Payment of any outstanding balance must be paid in full within 60 days, or payment arrangements can be arranged. Outstanding balances older than 90 days may be turned over to a collections agency. I ask you to provide a credit card to cover outstanding balances or any "no show" or "late cancellation" fees.

Health Insurance Portability and Accountability Act (HIPPA): My practice is HIPAA compliant. With this policy you may request a copy my HIPAA Privacy Notice. Signing this notice indicates you have received, read, understood and had the opportunity to ask me any questions about this policy. Please ask for a copy of the HIPAA Notice of Policies and Practices if you would like a copy for your records.

Client Endorsement: After reading these policies please sign below. By signing you are stating you understand and agree to these policies.

I have read this policy statement and understand its contents:

Print your name: _____

Client Signature: _____ Date: _____

Policies regarding payment and your financial responsibility:

Fee Schedule: Charges are based on length, complexity and type of service provided. The fee schedule below is a list of the most common potential charges. Exact fees cannot be determined until after service is provided.

SERVICE	LENGTH	BILLING CODES	FEE
New Patient Evaluation	60-90 minutes	CPT code 99205	$375
Medication Management (MM)	25 minutes	CPT code 99214	$200
MM and Therapy, depending on complexity	60 minutes	CPT code 99213-99214 + 90836	$255 / 325
Individual Therapy without MM	60 minutes	CPT code 90837	$225
No Show for appointment*			$100
Less than 2 business days notice cancellation			$100
Written documentation	15 min or more		$50 per 15 min
Telephone consultation	15 min or more		$50 per 15 min

Please be aware, it is my policy to terminate care after the third no show.

Insurance: I am in-network with Regence Blue Cross Blue Shield. I am happy to bill any insurance as a courtesy.

1. It is your responsibility to know if your insurance company covers my services. Charges not covered by your insurance company are your responsibility. You must notify me of any changes to your insurance coverage.
2. Call your insurance provider before your first visit to understand your coverage, including your deductible, co-pay, co-insurance and any restrictions.
3. A discount is offered for full payment at the time of service.
4. Insurance companies do not pay for missed appointments, phone sessions, written documentation and e-mails. If these services incur charges, you will be responsible for these.

Credit Card for Billing Purposes

Balances due on your account are your responsibility, regardless of insurance coverage. Please provide a credit card number to allow any outstanding balances over 90 days, no shows or late cancellations or arranged payments. You will receive a receipt of the charges by mail.

Card Type (circle one):	Visa		MasterCard
Card Number:		Security Code:	
Expiration Date:		Billing Zip Code:	
Name exactly as on card:			

I hereby give permission to charge any missed appointment fees or balances over 90 days to the card provided.

_____

Signature of card holder

I offer a limited number of low-income openings for patients without insurance coverage for mental health. A discount is applied for payment in full at the time of your visit. It is your responsibility to check with your insurance company regarding your coverage. For a list of questions to ask your insurance company, please check my website:

http://www.annapetros.com/Anna_Petros/Essentials.html