

WILLAMETTE VALLEY PSYCHIATRIC MEDICINE, LLC

PSYCHIATRY

859 Willamette, Suite 330, Eugene, OR 97401

T (541) 344-5363 F (541) 344-5369

NOTICE OF OFFICE POLICIES AND PROCEDURES, *EFFECTIVE 6/1/2019*

PURPOSE OF THIS INFORMATION

In order for me to provide the best care possible, I want my patients to have as much pertinent information as is possible. If you have any questions or concerns about the healthcare or business practices of this office please feel free to discuss them with me.

PRIVACY AND RELEASE OF INFORMATION

Services you receive in this office are confidential, except in the circumstances listed below.

1. Threats of harm to self or others
2. Abuse of a child, vulnerable adult, or developmentally disabled person
3. A court order to release information
4. Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen (14) days.
5. If you will be applying your health insurance benefits, we may be required to provide information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing the Acknowledgement of Receipt of Office Policies and Procedures form you consent to release of that information to your health plan. *Psychotherapy notes are handled separately under HIPAA and have additional protections.*
6. If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment in this office.
7. In some instances, as provided by the state law of Oregon, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

In circumstances other than these, I will not release information about your treatment without your authorization.

EMERGENCY CONTACT

Messages left on voicemail are retrieved regularly during business hours and calls are returned as soon as possible. If you need more rapid attention for your own or someone else's safety, do not delay while waiting for me to return your telephone call. *Please call 9-1-1 or report to the nearest hospital emergency room.* The on-call psychiatrist can be reached after hours or when the office is not open by calling the office and following greeting instructions. There may be a \$25 charge for after-hours *non-emergency* calls to the on-call physician .

PATIENT RECORDS

An electronic record (file) is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected with an addendum by submitting a written request. You may authorize in writing that copies of the record be released to entities you designate, at your expense, according to charges stipulated by the state law of Oregon. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record

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and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record upon written request.

SECURITY PROCEDURES

I make reasonable efforts to prevent access and disclosure to unauthorized personnel. I keep an ongoing log of potential risks and the physical and electronic safeguards implemented to limit these risks. I require my business associates to abide by all applicable privacy regulations.

INSURANCE BENEFITS AND PATIENT RESPONSIBILITY FOR FEES

Only your health insurance plan can describe your benefits to you or verify provider eligibility. My administrative staff will help you obtain this information from your health insurance plan, but you must contact the health insurance plan directly for verification. If charges are denied by a health insurance plan they become entirely your responsibility, even if you had understood from your health insurance plan that the charges would be paid by them. The clinic cannot accept responsibility for collecting or resubmitting an insurance claim after 90 days or for negotiating a disputed claim. Ultimately, you are responsible for the timely payment of your account.

FEES AND PAYMENT

Payment for charges not covered by your health insurance plan (including co-payment, co-insurance, and deductible amounts) is due in full at the time services are provided unless prior arrangements have been made. If the office will not be billing an insurance company for your visits, payment at a discounted rate is due in full at the time of service. Rates are subject to change; changes will be posted in advance.

UNPAID BILLS

It is important that you discuss with me any financial hardship that you may have. Doing so may allow us to arrive at a mutually agreeable payment plan that allows the continuation of your treatment. If this cannot be accomplished, seriously delinquent accounts may be referred to a collection agency and will be charged a \$50 collection fee. We may have to terminate our relationship as provider and patient. Information necessary to effect collection will be released to the collection agent. Should it become necessary to file suit in this context, you agree to pay reasonable attorney fees.

LATE CANCELLATIONS AND MISSED APPOINTMENTS

Missed appointments, not cancelled prior to the appointment, are charged at 50% of the full fee of the scheduled appointment. There is a charge for appointments cancelled **less than 2 full business days prior to the appointment**- \$35 for the first occurrence and \$60 thereafter.

Please note that insurance health plans do not pay for missed appointments or late cancellations; these charges will be entirely your responsibility.

As a courtesy, we will attempt to reach you with an appointment reminder 2 business days before your appointment; please be sure to update your contact information when it changes.

Options for these reminders include phone calls, text and email messages.

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MEDICATIONS

Please call your pharmacy for prescriptions refills even if you have no refills left; the pharmacy will contact the office to authorize further refills if needed. You may call the office if you need a written prescription. Please allow 48 hours for processing.

GRIEVANCE PROCEDURES AND COMPLAINTS

If you have any questions or concerns about administrative or business matters in this office, please discuss them with me.

If you have any questions or concerns about your treatment, you are encouraged to discuss them with me. In addition, or instead, the following avenues are available:

1. You may contact your health insurance plan or behavioral health benefit manager;
2. If you feel the problem is serious and/or you have not reached resolution through one of the avenues above, you can file a complaint with the Oregon State Department of Health.
3. You may also file complaints regarding privacy practices to the Secretary of the U.S. Department of Health and Human Services.

FEES

Fees are \$460 for the first visit, approximately 60 minute new patient evaluation.

Subsequent visits for established patients: \$175-\$325, based on length of time spent.

Additional psychotherapy may incur an add-on charge: \$140-\$250.

Please discuss any questions you may have about these fees or billing with your physician or the office staff.

If we are not billing insurance, self-pay discount rate of \$368 for the first visit, 60-75 minute new patient evaluation.

Subsequent visits with discount applied are as follows:

\$260 for 45-50 minute psychotherapy session with evaluation and management of medication.

\$200 for 20-30 minute psychotherapy session with evaluation and management of medication,

\$140 for 10-15 minute evaluation and management of medication.

Miscellaneous fees, likely not covered by insurance plans and therefore your responsibility:

\$25 for after-hours, non-emergency phone call to on-call psychiatrist

\$5 for completion of forms, per page

Medical records: \$18 for pages 1 to 10, \$0.25 per page for pages 11 to 20,

\$0.10 per page for pages 21 and greater

\$90 for report preparation, physician time, per 15 minutes

\$10 for returned check (non-sufficient funds or other reason)

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the State of Oregon. This includes issues relating to your treatment, payment, and our healthcare operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machine messages, and postcards.

PATIENT RIGHTS

You have the right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

Willamette Valley Psychiatric Medicine, LLC
859 Willamette, Suite 330
Eugene, OR 97401

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Willamette Valley Psychiatric Medicine's Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name.