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Seattle, WA 98133
PHONE: (206) 402-3375 ·
FAX: (206) 492-2020

PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

ABOUT THIS NOTICE

We understand that health information about you is personal, and we are committed to protecting your information. We create a record of the care and services you receive at Psychiatry Northwest, LLC. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we *may* use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that are currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)

Under HIPAA, protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, transmitted, or maintained by Psychiatry Northwest in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

· **Treatment:** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

· **Payment:** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, we may need to give your health

plan information about your treatment for your health plan to agree to pay for that treatment.

· **Health Care Operations:** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose Information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

· **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services:** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care or to contact you to tell you about possible treatment options or alternatives for health-related benefits and services that may be of interest to you.

· **Minors:** We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

· **Research:** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, if they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst Psychiatry Northwest providers. We may use and disclose a limited data set that does not contain specific, readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

· **As Required by Law:** We will disclose PHI about you when required to do so by international, federal, state, or local law.

· **To Avert a Serious Threat to Health or Safety:** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. We will only disclose the information to someone who may be able to help prevent the threat.

· **Business Associates:** We may disclose PHI to our business associates who perform functions on our behalf or providers with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing or to

provide transcription or consulting services for us. All our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- **Organ and Tissue Donation**: If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation such as an organ donation bank- as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans:** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation:** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks:** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury, or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence:** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities:** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes:** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose

your PHI to defend ourselves in the event of a lawsuit.

· **Law Enforcement:** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

· **Military Activity and National Security:** If you are involved with military, national security, or intelligence activities, or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law**.**

· **Coroners, Medical Examiners, and Funeral Directors:** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

· **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt. Out.

· **Individuals Involved in Your Care:** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend, or any other person you identify your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

· **Payment for Your Care:** Unless you object in writing, you can exercise your rights under HIPAA that your health care provider does not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

· **Disaster Relief:** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

· **Fundraising Activities**: We may use or disclose your PHI, as necessary, to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

YOUR WRITTEN AUTHORIZATION IF REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures of PHI for marketing purposes.
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose PHI under the authorization. Disclosure that we made in reliance on your authorization before you revoked will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy:** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you, and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this Notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal *needs-based* benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Summary or Explanation:** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Electronic Copy of Electronic Medical Records:** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request, your record will be provided in a readable hard copy form.

· **Receive Notice of a Breach**: You have the right to be notified upon a breach of any of your unsecured PHI.

· **Request Amendments:** If you feel that the PHI, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice, and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

· **Accounting of Disclosures:** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list of accounting of disclosures, you may submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

· **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure, and to whom you want the restriction to apply.

· **Request Confidential Communications:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

· **Paper Copy of This Notice:** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.psychiatrynorthwest.com, or contact Psychiatry Northwest at info@psychiatrynorthwest.com.

· **Changes to this Notice:** We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

· **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: The Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hioaa/ for more information. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES FOR PSYCHIATRY NORTHWEST, LLC

__ I acknowledge that I read and/or received a copy of the Psychiatry Northwest, LLC Patient Notice of Privacy Practices effective.

Signature: _____ Date: _____

New Patient Information

First Name: _____Last: _____ M.I. ___

Address:_____ City: _____ State: ____ Zip: _____

Marital Status: S M D W Sex: M F X Date of Birth: __ /___/_____ Age:_____

Primary Phone: _____Email Address: _____

Employer: _____

Employer Address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Email Address: _____

Address:_____ City: _____ State: ___ Zip: _____

Insured or Responsible Party (Policy Holder) Insurance Information

<u>Primary Insurance:</u>
Policy Holder Name: _____ Relationship: _____

Soc. Sec. #: _____Date of Birth: ___/____/____

Name of Insurance Company: _____ Effective Date: _____

Member ID: _____ Group Number: _____

Employer: _____Work Phone: _____

Secondary Insurance:

Policy Holder Name: _____ Relationship: _____

Soc. Sec. #: _____ Date of Birth: ___/___/____

Name of Insurance Company: _____ Effective Date: _____

Member ID: _____ Group Number: _____

Employer: _____ Work Phone: _____

_____ I hereby assign medical benefits to which I am entitled to this office, unless revoked by me in writing. I authorize any information needed to be released to my insurance company for the purpose of authorizing and processing my claims.

____ I understand that I am fully responsible for and will assume all my charges not paid by my insurance.

Signature: _____ Date: _____

Clinician-Patient Agreement

Rights and Risks:

- You may ask questions about any aspect of the counseling process.

- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.

- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.

- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.

- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.

- I am required by law to disclose information pertaining to suspected child abuse; the inability to care for one's basic need for food, clothing, or shelter; and threatened harm to oneself or others.

- The court may subpoena counseling records.

- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.

- You may want to discuss further limits or exceptions of confidentiality.

Appointments and Prescriptions:

- All office visits are by appointment and may be scheduled through the front desk or counselor directly.

- Please arrive 10 minutes early for your appointments for parking, billing questions, and to fill out paperwork as needed. You use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes for a New Patient and 20 minutes for a Follow-Up.

- Late Cancellation (less than 48 hours before your appointment) and/or No-Show appointments are billed $50.00 for the missed appointment. In the case of illness, please notify us by email at info@psychiatrynorthwest.com or call the office at (206) 402-3375 and leave a message. If your appointment is cancelled or missed, contact the

office for a new appointment as soon as possible. Insurance companies DO NOT pay for No Show charges or late cancellation charges.

• We will not refill a prescription if you have not been seen by a provider within 3 months.

• Prescription requests may take up to 5 business days to be filled. It is your responsibility to contact us and plan to have enough medication while your request is being processed.

• To improve medication management, we will only send prescriptions to one pharmacy of your choosing, designated in this packet.

Signature: _____ Date: _____

Prescription Refill Policy

To maintain our high standard of patient care, we monitor and manage medications with regularly scheduled appointments at least once 90 days and usually more frequently initially. **By law, we cannot refill any controlled prescription until after you have had another appointment with one of our providers.** We will do our very best to schedule you as soon as possible if a medication runs out unexpectedly.

i.e., Suppose you miss your follow-up appointment for a controlled substance (such as a stimulant for ADHD). In that case, we cannot send a refill for you, even when the missed appointment was due to unforeseen or uncontrollable circumstances. Additionally, we cannot refill controlled medications if they were left at home while traveling or if the medication has been lost or stolen.

Please help us by ensuring you have follow-up appointments scheduled one week prior to running out of your medication; your provider will try to help facilitate this but nobody's perfect.

Our commitment to you:

- All prescriptions are electronically sent to your pharmacy on the day of your appointment. These prescriptions are "on file" with your pharmacy and can be filled every 28 days for up to 90 days at a time. Sometimes prescriptions are only filled for 1-4 weeks to facilitate faster medication adjustments and improvement. If you are unsure what your medication refill schedule is, please email us at info@psychiatrynorthwest.com or ask your provider at your next scheduled appointment.
- Emails are checked regularly throughout the business day. Inquires will be acknowledged within 2-3 business days; processing may take 5 business days. If you send an email on Friday afternoon, your inquiry will be addressed no later than the following Wednesday.

What if I thought I had refills, but my pharmacy is not notifying me?

Check with your pharmacy to update your contact information if you think it could be out of date. If you have refills left on your bottle and have been seen within the last 90 days, then you may need to call the pharmacy to request the prescription "on file" to be filled every 28 days. Some pharmacies do not enroll you in their auto-refill program by default. If you do not have a prescription "on-file," or if it has been three months since your last visit, please call our office to schedule a medication follow-up appointment.

What if I'm having trouble picking up my prescriptions?

Check with your insurance company to see if they have a preferred online or home delivery pharmacy (i.e., philrx, express scripts, optum Rx, etc.) that can provide 90-day prescriptions delivered to your doorstep. Printed prescriptions for controlled substances are sometimes but not always required. Please let your provider know, and we will make this switch during your next appointment.

Why do I sometimes have to make two appointments at once?

An appointment with your provider is required following the completion of dose testing these medications. Please ensure your follow-up is scheduled before beginning the dose trial, as these appointments should be only 1-2 weeks apart, and our provider's schedules fill up quickly.

What do I do if my pharmacy says my medication is out of stock?

Rarely will we prescribe a medication that your pharmacy does not have in stock because of a local or national shortage. Unfortunately, our providers have no way of knowing this beforehand. In this situation, it is your responsibility to contact a pharmacy that has the medication in stock and then ask your pharmacy to transfer the prescription to this new pharmacy. We have found this is the fastest way for you to get your medication in this situation.

How do I change my pharmacy?

If you need to change pharmacies, you can let your provider know during your next appointment. If it needs to happen emergently, call your pharmacy to ask them to forward your prescriptions to the new pharmacy and alert our office by email: info@psychiatrynorthwest.com. Please allow 5 business days before your next scheduled medication auto-fill.

- In the email subject line, include "Change of Pharmacy" with the patient's name and date of birth.
- In the email body, include the patient's name and phone number with the new pharmacy name, address, and phone number.

What if I need an emergent non-controlled psychiatric medication Refill?

If there should be an emergency where you require a refill of a non-controlled medication that no longer has any refills due to being lost, stolen, or not refilled due to a missed appointment, then a small refill to bridge until our next soonest appointment will be at the

discretion of each provider and will take 5 business days for processing. To start this process, please email our office at info@psychiatrynorthwest.com and include the following information:

- In the subject line, include “Refill Request” with patient name and date of birth.
- In the email, body include the patient’s name and phone number with the medication name and dose, and the pharmacy name, address, and phone number.

Signature: _____ Date: _____

Network of Care Listing

To offer the best care possible, we may need to coordinate care with your primary care provider and other providers that you see as a part of your overall health. Please provide us with the contact information for your primary provider and all other providers in your care network.

Primary Care Provider

Physicians Name: _____

Practice Name: _____

Phone number: _____ Email: _____

Therapist

Therapist Name: _____

Practice Name: _____

Phone number: _____ Email: _____

Specialist 1: Cardiovascular, Internal Medicine, Neurologist, Endocrinologist

Physicians Name: _____

Practice Name: _____

Phone number: _____ Email: _____

Specialist 2: Cardiovascular, Internal Medicine, Neurologist, Endocrinologist

Physicians Name: _____

Practice Name: _____

Phone number: _____ Email: _____

Specialist 3: Cardiovascular, Internal Medicine, Neurologist, Endocrinologist

Physicians Name: _____

Practice Name: _____

Phone number: _____ Email: _____

_____ I hereby consent for Psychiatry Northwest to include my other providers listed above information that is appropriate for my total wellness plan medical benefits to which I am entitled to this office, unless revoked by me in writing.

Signature: _____ Date: _____

Emergencies
The best phone number for Psychiatry Northwest is (206) 402-337, our office hours are 8 am–5 pm, Monday through Friday. If it is after office hours and you are having a medical emergency, please call 911 or the 24-hour Mental Health Crisis Line: (866) 427-4747 or go immediately to your local hospital emergency room. If you leave a voicemail, your call will be returned on the next business day.

Weapons Policy
Under no circumstances are firearms or weapons of any kind permitted into this clinic. Regardless of personal carry license status, Psychiatry Northwest does not permit possession of weapons inside its facilities or on its premises.

Single Pharmacy Policy
Many of our patients require medications as part of their ongoing treatment plan; it is important for us to be able to establish a primary pharmacy to assist in your coordinated care. For our patients' convenience, our providers offer e-scripts to expedite medication refills and insurance prior to authorizations. We request that our patients use a single pharmacy for their prescriptions while they are being seen in our clinic. If there are extenuating circumstances that require you to fill your script at another pharmacy, your provider will evaluate these requests on a case-by-case basis.

Pharmacy Name_____ Phone _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ I have read, understand, and agree to the above policies. I have been offered a copy of these policies to take with me if desired.

Signature: _____Date: _____

HIPAA Email Consent

VERY IMPORTANT! PLEASE READ!

• HIPAA stands for Health Insurance Portability and Accountability Act.

• HIPAA was passed by the U.S. government in 1996 to establish privacy and security protections for health information.

• Information stored on our computers is encrypted.

• Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email. **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means that a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**

• Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to HIPAA, the federal government provided guidance on email and HIPAA.
• The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website — **http://www.gpo.govfidsys/pkg/FR-2013-01-25/pdf/2013/01073.pdf**

• The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send the patient personal medication information via unencrypted email.

OPTION 1 for HIPAA Consent — **ALLOW** UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to Psychiatry Northwest, LLC to send me personal health information via unencrypted email.

Patient Name: _____Date: _____

Signature: _____ Relationship to Patient: _____

OPTION 2 for HIPAA Consent— **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

Patient Name: _____Date: _____

Signature: _____ Relationship to Patient: _____

Consent to Care and Treatment at Psychiatry Northwest

I, _____, understand and agree to receive treatment for psychiatric care. I understand the following:

• I voluntarily consent to participate in behavioral health treatment (e.g., psychological, or psychiatric) by staff from Psychiatry Northwest, LLC.

• That I/We have been fully informed that services may include interviews, assessment or testing, psychotherapy, counseling, and/or medication management.

• That treatment may be provided by a licensed counselor, psychologist, psychiatric nurse practitioner, physician assistant, or psychiatrist.

• That this consent is given voluntarily.

• That I am legally competent and have the authority to provide consent for treatment.

• That I agree to participate in my treatment planning process to the best of my ability.

• That I have the right to withdraw my consent for this treatment at any time.

• That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Signature: _____ Date: _____

Appointment No-Show and Cancellation Policy

Thank you for entrusting your medical care to Psychiatry Northwest, LLC/TMS Washington. We strive to provide excellent care to all our patients. To be consistent, we use an appointment system to set a designated time for a patient to meet with our medical staff and discuss their treatment.

Missed appointments or no-shows are lost time for our physicians and providers. A Cancelation Policy has been instituted to ensure you notify our office of a cancellation within 48 hours of your scheduled appointment.

- In the event of a late cancelation (within 48 hours of your appointment) or missed (no-show) appointment, a $50.00 fee for Psychiatric Services will be charged to the patient account without insurance coverage.

- If you arrive halfway through your scheduled appointment and the provider is unable to accommodate a full appointment for you, your appointment may be marked as a no-show and you will have to reschedule your appointment.

- If there are three consecutive late cancellations or no-show appointments, it may result in the termination of care with our practice.

- For psychotherapist appointments, a no-show or missed appointment will result in the patient's account being charged for the full cost of the Psychotherapy Session without insurance coverage.

Out of respect to all our patients and providers, we request that you please give our office 48-hour notice if you are unable to keep your appointment. As a courtesy, you will receive reminder calls, texts, or emails prior to your appointment. If you do not receive the reminder, the Cancelation Policy will remain in effect.

___ I have read and understand the cancellation policy and agree to be bound by its terms.

___ I UNDERSTAND THAT I WILL BE CHARGED A $50.00 NO-SHOW FEE FOR ANY APPOINTMENTS NOT KEPT UNLESS 48-HOUR NOTICE IS GIVEN TO THE OFFICE.

Signature: _____ Date: _____

Financial Policy and Agreement

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office.

Insurance:

Our office participates with most insurance policies. It is your responsibility to:

- Bring your current insurance card to every visit and notify us of any changes in your insurance coverage.
- We will attempt to confirm your insurance coverage prior to treatment. It is your responsibility to know whether we are a contracted provider with your insurance plan.
- Be prepared to pay your copay, coinsurance, and/or deductible at the time of service. Payment may be made by cash, check, or debit/credit card.
- All copays and deductible amounts owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service.
- **If we are not contracted with your insurance plan, you will be considered a private, self-pay patient. This means that at the time of check-in you will have to pay self-pay rates.**
- **If you have elected to use our practice and our physicians are out of your network of coverage, please check with your insurance regarding benefit levels and how you can submit for reimbursement.**
- If you have questions regarding your coverage, please contact your insurance company or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
- As a courtesy we will submit a claim to your insurance company for you. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.

- You understand that your insurance carrier can choose to assign payments to Psychiatry Northwest, or your insurance may make payment directly to you. You understand and agree that you are financially responsible for all health care service charts that are paid to you directly by your insurance carrier.

Payment Details:

- We have the capability to accept payments over the phone with your debit/credit card information. We reserve the right to process your payment electronically based on the information you provide us.

- **Clients paying on a cash basis, and not billing any insurance company, are expected to pay in full at the time of service. Payment plans are only for past-due balances.**

- **Accounts become delinquent after thirty (30) days. Accounts 90 days in arrears will be terminated unless a payment plan is in place.**

- **Any change in financial situation should be discussed with the provider. In the event you find it necessary to change mental health providers and require records to be sent from Psychiatry Northwest, LLC, your account must be paid in full.**

_____ **I have read the financial policies contained above** and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: _____ Date: _____

Self-Pay Patient Payment Agreement

You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. Due to this cash payment, you are receiving a discount. We **will not** bill insurance for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

____I understand that I will be responsible for all charges related to the services provided to me by Psychiatry Northwest LLC/TMS Washington.

____I understand that the charges presented to me are due **in full** on the day of service unless arrangements have been made with the physician in advance.

Self-Pay Rates:

Physician Appointments
New Patient Evaluation: $350
Follow-Up Appointments: $150

PA-C and ARNP Appointments
New Patient Evaluation: $250
Follow-Up Appointments: $ 100

Psychotherapist and Mental Health Counselor
New Patient Evaluation: $175
Follow-Up Appointments: $150

QB Test (ADHD Diagnostic Exam): $150

_____I have read and fully understand the above self-pay rates, and I agree to waive insurance billing and pay my balance owed at the time of check-in. I also understand by signing this acknowledgement that I will be responsible to pay for the services rendered to me and/or my child.

Responsible Party Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____