



Northwest Psychological Center

Office Disclosures and Policies

FEES

1. Payment is required at the time of service. If you have insurance coverage, the business office will calculate your estimated co-payment to be paid at the time of service.
2. We accept personal checks, money orders, cash, Visa and MasterCard.

BILLING

1. We will bill your insurance company as a courtesy to you. Clients will receive statements once a month showing activity for the month. The estimated client balance due listed on the client statement is payable upon receipt of the monthly statement.
2. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment on your account, including any unpaid insurance claims.
3. If payment arrangements must be made, please contact the business office.
4. Accounts carried 90 days without payment may be turned over to a collection agency. If a delinquent account is placed in the hands of a collection agency, the client agrees to pay all collection agency charges and expenses, reasonable attorney fees, and court costs as fixed by the court. If your account is turned over to a collection agency, it may affect your credit rating.

CANCELLATION AND MISSED APPOINTMENTS

Scheduled appointment times are reserved especially for you. The initial consultation session is approximately one hour, and each follow-up session is 45 minutes. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed according to the scheduled fee and instructions of the benefit plan. Repeated no-show appointments could result in termination of treatment and referral to another practitioner. Your insurance company will not be billed for fees associated with missed or canceled appointments.

LIMITS OF CONFIDENTIALITY STATEMENT

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.

3. The patient presents as a physical danger to self
4. The patient presents as a danger to others
5. Child or Elder abuse and/or neglect are suspected

DISABILITY/FORENSIC DISCLOSURES

We do not participate in disability claims, worker's compensation, or personal injury cases. If you apply for disability, please note that I do not fill out any disability forms nor provide any information to your carrier regarding your disability status. If you plan to use psychological information for your disability determination or status, I will be happy to refer you to another provider who is able to provide information for such determination. Likewise, if you have a worker's compensation claim or personal injury claim, I do not participate in such claims. I do not render any clinical opinion nor provide psychological information for such determination.

EMERGENCIES

In case of emergencies, please call 911, go to your nearest hospital emergency room, or contact Clackamas County Crisis line at (503) 655-8401.

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological exams, treatment, and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. Your treatment may be brief or long-term depending on your condition, treatment objective, and treatment response. If treatment is ineffective or progress is not made within a reasonable time, treatment may be adjusted. If that is still ineffective with minimal or no progress, your provider may consider referring you out after discussing this with you.

Please sign below indicating your understanding of the information above. If you wish, the office will provide you with a copy of this policy.

Signature of Responsible Party

Date