## *OFFICE POLICIES and CONSENT FOR TREATMENT*

This is to familiarize you with my office policies. Your signature signifies that you have read, understood, and agreed to abide by these policies and that you have received a copy of these policies for yourself.

**Confidentiality**:
Communication during the course of your treatment, your treatment plans and any information about you will be kept confidential and will not be shared without your written consent. Your signature is required before I can share or receive information from other providers. There are a few exceptions to this policy:

- When there is reason to believe you may be in danger of harming yourself or another person.
- When there is reasonable cause to believe child abuse or neglect has occurred.
- When an emergency situation requires sharing of information.
- When required for insurance billing purposes. When a court order is received.

**Confidentiality and treatment of children and adolescents:**
I believe in maintaining confidentiality and will respect this except in those instances listed above and for any necessary communication with parent/guardian for treatment planning. Parent/guardian participation in treatment of minors is important and in most circumstances is required for effective treatment. Oregon law allows clients 14 years and older to consent to their own mental health treatment by a nurse practitioner but requires the nurse practitioner to involve the parents prior to the ending of treatment except in rare instances. It is recommended that parent/guardians be involved in treatment unless there are extenuating circumstances. Clients under the age of 14 are required to have parent/guardian consent for treatment.

**Client Participation/Rights:**
Treatment will only be effective if the client is engaged and actively involved; this includes family members of children and adolescents seeking treatment. I believe in working together toward treatment goals. It is important to ask questions about treatment if you are unclear about any aspect of treatment plans or goals.

**Fees:**

| | | |
|---|---|---|
| Initial Evaluation: | 2 hours | $426 |
| Consultation | 60-90min | $399 |
| 20-30 minute appointments: | | $236 |
| 45+ minute appointments: | | $326 |
| 75+ minute appointments: | | $376 |

Missed Appointments – require 48 hr notice

| | |
|---|---|
| 1st | No Charge |
| 2nd and Beyond 30min / 45-60min | $236 / $326 |

**Payment:** Please make checks payable to Maggie Alexander NP. You may use a debit or credit card. If payment is not received, services may be discontinued. **Payment in full is expected at the time of service.**

**Insurance:** You are responsible to check with your insurance company regarding your coverage and to track your coverage. You are responsible for all charges not covered by your insurance company.

**Cancellations: Please call me to cancel appointments, providing at least 48 hours' notice; this includes weekends if your appointment is on a Monday.** If you fail to cancel your appointment within 48 hours, you will be charged the full cost for your appointment, at the rate listed above. Insurance companies will not pay for missed appointments and you will be held responsible for the full (above) cost of the missed appointment. I will forgive one missed appointment per year as long as you call me ahead of time.

**Telephone messages and Emergency/Urgent Services:**
I check my voicemail at least once per day and attempt to return all calls within 24-48 hours of receipt of a voicemail. I do not carry a 24 hour pager. During weekend hours and when I am out of town my voicemail will direct you to the covering provider who can assist with URGENT matters only.

**Emergencies:** For after hour emergencies, please call 911 or go to the nearest emergency room. Emergent situations include serious psychiatric medication reactions or risk of harm to oneself or someone else. In the event of a mental health crisis, you may also contact:
Washington County Crisis Line **503-291-9111** Multnomah County Crisis Line at **503-988-4888**

**Non-Urgent Calls:** For non-emergency matters, please leave a message on my confidential voice mail number at **503 530 – 9766** during or after business hours or on weekends. If I am away for an extended period of time, my message will provide information on who is providing coverage for my clients. Appointment changes are considered non-urgent calls.

**Prescription Refills:** Refills of medication are usually written at the time of your appointment. If you are in need of a refill between appointments, please contact your pharmacy, and they will fax a refill request to me. Refills are not considered an emergency and will be handled between 9am and 5pm, within 48 business hours.

**Grievance Procedure:** I encourage you to discuss any complaints with me directly to resolve the problem or issue. I always strive to learn from these discussions. You may also contact your insurance company or the Oregon State Board of Nursing at: 17938 SW Upper Boones Ferry Rd, Portland, OR 97224-7012 or 971-673-0685.

**HIPAA Notice of Policies and Practices:** 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 (a) how clinical information about you may be used and disclosed, and (b) 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.

**SIGNATURE**

**Your signature below indicates that you have read this agreement and agreed to all of its terms. You understand that if the terms of this agreement are violated, your treatment in my practice may require termination. Your signature also serves as an acknowledgement that you have received the HIPAA Notice of Policies and Practices described above if you have requested it or agreed to review it on my website.**

_____

**Name of Client**

_____

**Signature of Client (or Personal Representative) Date**

_____

**Description of Personal Representative's authority**

_____

**Signature by Client under age 14 Date**

_____

**Date of Birth (only if client is under age 14)**

**Notice of Privacy Practices and Professional Disclosure Statement Receipt and Acknowledgment of Notice**

**Client Name:** _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Maggie Alexander, PMHNP's Notice of Privacy Practices and Professional Disclosure Statement. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Maggie Alexander, PMHNP.

_____

**Signature of Client** **Date**

**If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: _____ Relationship to Client: _____

**For Office Use Only**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

**This form will be retained in your medical record**

## POLICY STATEMENT

**Confidentiality**

Communication between client and provider/therapist is confidential, even if the client is a minor, and may be shared only for the purpose of consultation without the client or parent/guardian present. You will be informed in the event that any information is released without your express consent. Information may be released without written permission only: 1) if a court order is received, 2) when there is reasonable cause to believe that child/elder abuse or neglect has occurred, 3) when there is reasonable cause to believe that there is clear and imminent danger to self and/or others, 4) when a medical emergency exists, and 5) when required for insurance billing. **A release of information must be signed before any information can be provided to or requested from other individuals or agencies.**

**Client Responsibilities**

- Become actively involved in the treatment goals and share periodic reviews with your provider to assure each other of productivity and that we are working toward desired outcomes. If the client is a minor, the parent(s)/guardian(s) of the child agree to actively participate in the healing of the family by establishing family treatment goals
- Assume control of all payments to the provider at the time of the appointment
- Notify the provider no less than 48 hours in advance of any cancellations.
- Failure to comply with the cancellation policy will result in a missed appointment fee.

Insurance companies do not typically reimburse patients for these costs and the client will be directly held responsible for these costs.

**Telephone Messages and Emergency Coverage**

You may reach me or leave a voice-mail for me at 503-523-9629. I work part-time and only return calls on days I am in my office. If I am away for an extended time period, the message will direct you as to who is providing coverage for my patients. In the event of an emergency, call 911 or go to the nearest emergency department. I do not carry a 24-hour pager.

In the event of a crisis, you may contact:

- Emergency (police, fire, ambulance) 911
- Multnomah County Crisis Line 503-988-4888 or 1-800-716-9769
- Washington County Crisis Line 503-291-9111
- Clackamas County Crisis Line 503-655-8401
- Clark County Crisis Line 360-696-9560
- Portland Women's Crisis Line (domestic violence) 503-235-5533
- Rape Crisis Center 503-640-5311
- Poison Control 503-494-8968 or 800-452-7165
- Oregon Council on Alcoholism and Drug Abuse Hotline 800-923-4357
- Cascadia 24-hour Urgent Walk-In Clinic (Located at 2415 SE 43rd Ave – near Division)

**Prescription Refills**

- Refills of medication usually are written at the time of your scheduled appointment.

- Prescription refills are not emergencies, and must therefore be handled during regular business hours- Mon-Friday, 9 am-5 pm.
- Please contact your pharmacy and have them fax me a refill request at 503 992-6625, allowing 72 hours for refills to be completed on business days.

**Payment Agreement**

1. It is your responsibility to know if your insurance covers my services. Charges not covered by your insurance are your responsibility. It is also your responsibility to notify me of any changes in insurance coverage.
2. It is customary to pay for professional services when rendered. Payments must be made or services may be discontinued.
3. If you have a balance on your account, you will receive a statement. All accounts are due and payable within thirty days of notification. If payment is not received within 60 days, a late fee will be applied. If a client fails to be responsible for the account, and it is necessary to place a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all court costs affixed by the court.
4. If you have a question regarding the payment of fees, please discuss this with me.
5. If you late cancel (cancel with less than 48 hour notice) or miss an appointment, you will be charged the total appointment fee. Insurance companies typically do not pay these fees and it will be your responsibility to pay these costs. Additionally, insurance companies do not typically pay charges for phone sessions or written documentation. You will be asked to pay for these charges directly.
6. All checks are to be made out to Maggie Alexander, NP.
7. There is a $35 service charge for NSF/Returned checks.

**Length of Treatment**

Individual therapy typically involves regularly scheduled weekly or bi-weekly sessions.
Medication management sessions are more frequent in the beginning, or after any changes are made, and then typically occur monthly or bi-monthly. Duration of treatment varies depending on the nature of the treatment and individual client needs. When medications are used in psychiatry, please be advised that they are frequently used "off-label" meaning that they are used to control symptoms other than what the FDA originally approved the medication to treat. This is especially true in children. Patients must be seen at minimum every 90 days to be considered active patients with Maggie Alexander, PMHNP. Should you not schedule an appointment for a period of 90 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client of Maggie Alexander, PMHNP and therefore have terminated treatment. Also, if you "no show"/ "late cancel" for two consecutive appointments or "no show"/ "late cancel" for one appointment and do not reschedule within thirty days, you will be considered to have terminated treatment with Maggie Alexander, PMHNP.

**Grievance Procedure**

I encourage you to discuss your complaint with me directly to resolve the problem/issue. You may also contact your insurance company. Additionally, I am licensed through the Oregon State Board of Nursing. It also has a process for hearing complaints. You may contact the Oregon State Board of Nursing at: 17938 SW Upper Boones Ferry Road, Portland, OR 97224-7012, or at (971) 673-0685.

**Client Endorsement**

After reading these, policies please sign below. By signing you express that you understand these policies. You can request a signed copy for your records. I have read this policy statement and understand its provision.

PRINTED CLIENT*: _____

SIGNED: _____

DATE: _____

*IF CLIENT 14 years or older, must be signed by client

PRINTED NAME of PARENT / GUARDIAN: _____

SIGNED: _____

DATE: _____

**INFORMED CONSENT FOR EVALUATION AND TREATMENT**

1. You have the RIGHT TO BE INFORMED REGARDING The terms UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED. Policies related to charged; billing third party payers, appointments, emergencies, and coverage for when your provider is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluation. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best matches your needs. You also have a right to a detailed explanation or any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your provider and she will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING of your provider. You may request a provider information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the provider directly. If the difficulty is not resolved, you have the right to make a formal complaint to the Oregon State Board of Nursing.
4. You have the RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT at any time and for any reason. In the case where a minor is the patient/client, then parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. If you have concerns regarding your treatment or wish to discontinue, you are encouraged to discuss this with your provider.
5. You have the RIGHT TO CONFIDENTIALITY. This means that what you tell your provider and what is contained in your clinical file will not be repeated or released by the provider to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider.
6. For minors 14-17 years old, psychiatric mental health nurse practitioners may provide treatment to a fourteen year-old without consent of his/her parent. Oregon law requires your provider to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Maggie Alexander, PMHNP does not need to involve your parents in treatment if you have been sexually abused by your parent or if you are emancipated. It is the policy of Maggie Alexander, PMHNP to notify the parents on or before the third session. By signing this informed consent document you:

a. Authorize Maggie Alexander, PMHNP to contact your parents and to give them a summary of your treatment.
b. Authorize your provider to use her best clinical judgment on when to inform you parents of important issues related to your treatment.
c. Authorize Maggie Alexander, PMHNP to release your treatment records to your parents upon their request. It is the policy of Maggie Alexander, PMHNP to require both you and your parents to sign any release of information to anyone other than your parents.

There are, however, some limits and exceptions to complete confidentiality:

a. CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agency.
b. VIOLENCE: If a provider learns that someone is about to kill or to do harm to someone else, she will do her best to warn the intended victim.
c. SUICIDE: If a provider earns that a client intends to harm her/himself, the provider will breach confidentiality to the extent necessary for the client's protection.
d. NON-CUSTODIAL PARENTS: By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluation.
e. SUPERVISION: Your provider may present your case in clinical staffing and also periodically review and discuss your treatment.

CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers regarding your treatment (e.g. medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy.
INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in Maggie Alexander, PMHNP informed consent for evaluation and treatment form. Furthermore, by signing this form, I consent to receive mental health services to be provided by Maggie Alexander, PMHNP.

PRINTED NAME: _____ DATE:_____

SIGNED*: _____ *If client 14 years or older must be signed by client.

PRINTED NAME of PARENT / GUARDIAN: _____

RELATIONSHIP TO CLIENT: _____

SIGNED: _____ DATE: _____

## Maggie Alexander, PMHNP, LLC Psychiatric Mental Health Nurse Practitioner

### Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

Client Name_____ DOB_____/____/_____

Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____ Social Security Number:_____

I, the undersigned, hereby authorize Maggie Alexander, PMHNP, to send information to billing representatives. I, the undersigned, hereby authorize Maggie Alexander, PMHNP and its billing representatives to send information to:
Insurance Company: _____ Subscriber: _____
ID Number: _____ Group/Policy #: _____

Secondary Insurance : No ☐ Yes: ☐
Insurance Company: _____ ID Number : _____ Subscriber:_____DOB____/___/___ Group/Policy #: _____

I, the undersigned, certify that I have Neither Medicare or Medicaid.

Purpose of Disclosure (please initial):
____ Authorize to bill insurance named above and coordination of billing issues between Maggie Alexander PMHNP its billing representatives

Information to be released is (please initial):

____ Diagnosis
____ Psychosocial History
____ Treatment plan or summary
____ Psychological Evaluation/Reports
____ Psychotherapy Notes
____ Chemical Dependency
____ HIV or AIDS information
____ Other

Required Statements:
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under Federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment from Maggie Alexander, PMHNP, unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure. If I do not sign this authorization, I understand that Maggie Alexander, PMHNP, will not be able to bill my insurance. I will be required to pay "Cash Pay" based on the fair and customary rate for all mental health treatment at Maggie Alexander, PMHNP.

I may revoke this authorization in writing at any time. If I do so, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. If I revoke this authorization, I understand I will enter into the "Cash Pay" arrangement described above as Maggie Alexander, PMHNP, will not be able to bill my insurance.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this authorization shall expire twelve months from the date signed. Other (specified): _____

I have read this authorization and understand it.

_____
Signature of Client Date

_____ _____ _____
Subscriber Signature Relationship to Client Date DOB of Client
*If patient is 14 years or older form must be signed by patient.

Subscriber SSN if subscriber is a minor: _____

**Maggie Alexander, PMHNP, LLC Psychiatric Mental Health Nurse Practitioner**

1675 SW Marlow Suite 315, Portland, OR 97225 Telephone: 503 523-9629

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER**

I,_____, hereby authorize Maggie Alexander, PMHNP to receive information from and/or send information to the clinician indicated below. This release pertains to the following types of information: medical history, mental or physical conditions or treatment, including information relating to my mental health diagnosis and/or substance abuse diagnosis and treatment to my primary care provider.

Clinician Name: _____

Clinician Address (Street, City, and Zip): _____

Clinician Phone Number and/or Fax Number: _____

This authorization for release extends to the care and treatment the client received during:

☐ All dates of service or

☐ Service between_____and _____

This information may be used for the following purpose(s):

☐ Evaluation, assessment and/or treatment and/or ☐ Ongoing coordination of treatment and/or

☐ Other: _____

The information to be released is:

□ Diagnoses □ Psychological Evaluations/Reports □ Medical Evaluations

□ Treatment Plan or summary □ Chemical Dependency Information □ Other: _____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire:

One year from date signed or □ Upon termination of treatment or □ Other:_____

_____ _____

Signature of client, parent, or legal guardian Date signed

_____ _____

Witness Date signed

**FOR Maggie Alexander, PMHNP TO COMPLETE:**

Primary Care Provider: _____

The purpose of this letter is to notify you that your patient_____, (DOB:_____)

has begun mental health services with me. I believe it is important to coordinate mental health medical services with the medical care, which you are providing. I will be contact in you as needed to discuss any concerns or questions that I have regarding the mental health issues. To the above address or fax number, please send any information that you deem important to the mental health services being provided or call. Thank you. DSM-IV Diagnosis:

Axis I:_____

Axis II:_____

Known Current Psychotropic Medications: ☐ None _____

_____

Medical Condition/s: _____

Treatment (Therapy) Modalities: ☐ Individual ☐ Family ☐ Couples ☐ Group ☐ Other:

Estimated Length of Treatment: ☐ 3 months ☐ 6 months ☐ 9 months ☐ Other:

Please help monitor these risks: ☐ None ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Poor self-care

Coordination of Care Issues: _____

_____

_____ _____

**Maggie Alexander PMHNP-BC** **Date**

**Maggie Alexander, PMHNP, LLC Psychiatric Mental Health Nurse Practitioner**

1675 SW Marlow Ave., Suite 315 Portland, OR 97225 • Telephone: 503.523-9629 • Fax 503-992-6625

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Client Name _____DOB _____/_____/_____
Street Address: _____
City, State, Zip Code: _____/_____/_____
Telephone Number: _____

**I authorize Maggie Alexander, PMHNP, LLC**

**Check appropriate spaces and initial and give complete name and address:**

___**To give health records to:**
___**To receive health records from:**
___**To verbally exchange health information with:**

Name: _____
Street Address: _____
City, State, and Zip Code: _____
Telephone: _____
Fax Number: _____

**For the purpose of continuing care or:** _____
___ **All information in chart**
___**Specific information to be released:**_____,
if such information exists:

____Mental health related information
____Drug/alcohol diagnosis, treatment or referral information
___HIV/AIDS related records
___Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:
_____ All dates of service _____ Service between _____ and _____

Required Statements:
This authorization will expire in one (1) year or upon (insert date or event) _____

I may revoke this authorization in writing by presenting my written revocation to Maggie Alexander, PMHNP, LLC.
The revocation will not apply to information that has already been released in response to this authorization. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Maggie Alexander PMHNP, LLC is not responsible for the cost of copies.
I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

Signature of Client*_____Date_____

Signature of Personal Representative_____Date_____

Relationship to Client_____
*If patient is 14 years or older form must be signed by patient

**Maggie Alexander, PMHNP-BC**
1675 SW Marlow Avenue, Suite 315 Portland, Oregon 97225 p. 503 523-9629 f. 503 992-6625

**CREDIT CARD AUTHORIZATION FORM**

**Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.**

I,_____on behalf of_____,
authorize Maggie Alexander, PMHNP to charge my credit card for professional services rendered to myself or my child as follows:

Please Initial Where Appropriate:

_____ Recurring charges for services in the amount of $_____
_____ Per Visit
_____ Per month on the _____ day of each month per our signed payment arrangement plan

_____ I understand and agree that my card will be charged the full fee of the scheduled appointment for cancellations with less than 48 hours' notice and for appointments I miss without notice as agreed to in the office policies I signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance as outlined in the office policies I signed (all visits, phone calls, letters, emails, and consults).

_____ I understand this form is valid until I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy. I further understand that I am responsible for updating my credit card information in the event that it should change, and that I am responsible for any fees incurred for a declined credit card transaction.

_____ I understand and agree that my card may be charged without me being present and that a receipt of payment will be sent to me within 48 hours of charges being placed on my card.

**Charges will appear on your credit card statement as Maggie Alexander, NP**

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (the 3 digit code on back of card by signature line): _____

Billing Address: _____

City_____ State _____ Zip _____

EmailAddress:_____

Signature_____

Printed Name_____ Date_____