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: 4 Hours	$426
60-90min consultation	$399
20-30 minute appointments:	$236
45+ minute follow-up appointments:	$326
75+ minute follow-up appointments:	$399
Missed appointments- require 48 hour notice	
1st	no charge
2nd and beyond	$236/ $326

Returned Check Fee	$ 50	
Nonpayment past 60 days:	$ 50	(+$15 for each additional 30 days past due)
Services over 10 minutes	$ 50	per each 10 minutes

*This includes ***phone calls, letters, and emails*** with you, schools, hospitals, health care providers, and therapists. **Please note that insurance does not pay for these services**.

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.

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Name of Client

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

_____

Description of Personal Representative's authority

_____

Signature by Client under age 14 **Date**

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

1675 SW Marlow Ave, Ste 315, Portland, OR 9225 ♦Phone: 503 530-9766 ♦Fax: 503 992-6625
Reviewed 01-29-2020