# Office Policies

**This statement contains information regarding my office policies. Please read it carefully and if you have any questions, discuss them with me.**

**Appointments** are usually 55-60 minutes long. Your appointment time is held exclusively for you. Please arrive on time as you use your own time when you are late. If you are going to be unable to keep an appointment, you are asked to provide 24 hours' notice or you will be charged for the time as if you attended. Please note: insurance companies will not cover this charge and you will have to pay the entire amount out of pocket.

**Office Hours, Appointments and Emergencies** I share this suite of offices with a number of other mental health practitioners. Each of us is in independent practice. We have no responsibility for each other's businesses or patients. My office hours are: Salem: Tuesday 8:00-7:30 and Wednesday 1:00-7:30, Lake Oswego: Monday, Wednesday morning, Thursday, and Friday. To schedule an appointment, call 503-329-5678 and leave a message. I will call you back as soon as possible. If you need immediate support before I call, please go to the emergency room of your nearest hospital. When I am out of town, I am still mostly available by phone and, in an emergency, I can arrange for you to be seen by another psychologist.

**Fees** The fee for my professional services is $275.00 for the first session and $175.00 for 55-60 minute sessions thereafter. Shorter or longer appointments will be pro-rated at that same rate. You will also be charged this same rate for additional services provided at your request or for your benefit (at the request of an insurance company, attorney, etc.) such as report writing, psychological test scoring, consultation with other professionals, hospital visits, and phone calls over ten minutes with you or others. Payment in full is expected at the time of the visit unless my contract with your insurer prohibits collecting in full. This is also true for child patients, regardless of who brings the child to the visit, or if the child comes unescorted by an adult. For your convenience, you can pay your fees with your VISA, MasterCard, American Express, Discover or debit card. We are happy to keep your card information on file and charge your account automatically after each visit if you wish.

**Responsible Party** We will send the monthly billing statement to one household or one responsible party only. If two or more people from different households share financial responsibility for a patient's medical expenses, we will bill only one of them, the one who signed the intake forms accepting financial responsibility. If someone other than that person wishes to be the responsible party, he or she can fill out and sign intake forms, after which responsibility for the account can be transferred.

**Insurance** We will bill your insurance company monthly as a courtesy to you and will follow up with them to assist in getting reimbursement for services. However, you are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Am I a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for the entire bill whether the insurance pays or not. If you are seeing me for a forensic evaluation and I am a contracted provider for your insurance company, and if the evaluation is an included benefit, then I will not accept you as my patient. Forensic evaluations require a retainer paid in advance.

**Billing** I will use a billing service to prepare your bill and track your account. Please refer any questions you may have about your bill to Margaret Sears at Professional Practice Management (PPM), 503-528-8404. We bill monthly at the end of our billing cycle which ends on the 10th of the month. If, for any reason, you have a personal balance on your account, I will expect payment no later than the last day of the billing cycle. If such payment is not made, a $25.00 rebilling charge will be assessed for that month to offset the cost of keeping your account open. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

**Confidentiality and the Release of Information** Your participation in treatment and all information about you are confidential and will not be disclosed to anyone without your consent. Some exceptions are: (1) Cases of suspected abuse or neglect of a child, disabled person or elder – ask me to explain more if you have concerns about this, (2) Cases where I believe the patient presents a clear and imminent danger to him/herself or to another person, (3) Cases where a court subpoenas me to testify or subpoenas my records – I will attempt to discuss this with you beforehand, (4) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment or requires a review for the purpose of quality assurance, (5) Cases where I consult with a colleague about my work with you (however, I would do this without using your name or identifying information). (6) cases where I consult with your other health care providers in order to coordinate your care.

**HIPAA Notice of Policies and Practices** I am committed to preserving the privacy of your personal health information. Additionally, 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 (1) how clinical information about you may be used and disclosed and (2) 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. HIPAA allows for you to pay out of pocket for the items or services that, for confidentiality reasons, you do not want billed to your insurance company. I will maintain a record of the visit in my files.

Your signature below signifies that you have read, understand and agree to abide by these policies and that you have received a copy of the policies for yourself. Your signature also serves as an acknowledgment that you have received or do not wish to receive the *HIPAA Notice of Policies and Practices.*

_____ _____

Signature Date

_____

Please print your name

**To contact Dr Johannsen: 503-329-5678 • cjohannsen@comcast.net**

**To contact the billing office: 503-528-8404 • professionalpracticemanagement@comcast.net**