SALEM PSYCHIATRIC ASSOCIATES

821 Saginaw St. S
Salem, OR 97302
TEL (503) 362-1999
FAX (503) 362-9671

Session Fees Policy

Acknowledgment Form

I, _____ (please print name) have read, had the opportunity to ask questions about, and understand the following policies related to my care at Salem Psychiatric Associates:

- Our office fees will vary depending on services that are provided. You should have received a handout of our charges and procedures with your welcome packet. If not, please ask for one.

- We have a couple of different payment options as we are providing both in/out of office appointments:
  - You can keep a credit card on file, and we will run it within a couple of days of your appointment.
  - You can pay by check or cash at the front desk if coming into the office.
  - You can request that we send a statement and pay with the statement.
  - You can call our billing office at **503-315-8646** and make a one-time credit card payment over the phone.

- Our office will be happy to bill your insurance as a courtesy to you.
  - Regardless of insurance coverage, full payment for appointments is your responsibility.
  - If you ARE NOT covered by insurance, the FULL FEE will be required at the beginning of each appointment.

- To ensure your participation in your care, if you have an unpaid balance on your account, we will not schedule another appointment for you until the payment is made.
  - If needed, you may make your payment over the phone by calling the billing department at **503-315-8646** and then you may schedule your next appointment.
  - Medications will be managed and refilled during your appointments, so prompt payment will allow prompt scheduling and ensure that medication management continues uninterrupted.

- If you have special circumstances and need to make payment arrangements, please work this out with our billing office prior to treatment. Our work together can best proceed when you address financial issues ahead of time.

- **Cancellations:** your appointment time is reserved exclusively for you. It is necessary for you to cancel appointments you cannot keep. There will be no charges for appointments cancelled **48 hours** or more in advance. If you do not attend a scheduled appointment or fail to cancel prior to the **48-hour** timeframe, you will be charged **$100**. Please see the section on Session Fees, below, for further information about scheduling your appointments only after paying outstanding balances.

- **Additional Policies Regarding Fees:**
  - Please know that there is a $25 charge for any returned checks.
  - Unpaid balances will be charged a 2% interest rate per month after a bill is past due.
  - Unpaid accounts will be turned over to a collection's agency after 3 months if there is no payment plan in place and a monthly payment is not received.

I hereby acknowledge the above policy and agree to the terms to support my treatment at Salem Psychiatric Associates.

To be signed by the individual responsible for all charges not covered by insurance:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

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Notice of Privacy Practices

I understand that **Salem Psychiatric Associates P.C.,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some of all my healthcare.
- Perform various office, administrative, and business functions that support my provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have a right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other personnel of This Practice, and my rights regarding my health information.

I understand that this Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in this Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I confirm that I have reviewed and understand the information above, and that I may request a copy of the Notice of Privacy Practices at any time.

To be signed by patient (if 14 years or older and able to consent to treatment) *:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Power of Attorney

***Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675).**