**David E. Blakeslee, Psy.D., P.C.**
4000 Kruse Way Place, Bldg. 2, Suite 200
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# Office Policy

Our goal is to provide and maintain a good doctor-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully; if you have any questions, please do not hesitate to ask us.

**Appointments**

1. After your initial appointment, a regular appointment time will be arranged for you. Therapy works best when regular appointments are kept.
2. We value the time set aside to see you – it is time reserved **just for you**. If you are not able to keep an appointment, please give at least 24 hours' notice.
3. *Appointments are important; therefore, there are fees charged if appointments are not kept.*
    a. *Appointments canceled less than 24 hours prior to the appointment -- $83.*
    b. *Missed or no-show appointments -- $165.*

**Initial: _____**

**Emergencies**

If you should have an emergency which cannot wait until your next appointment, I am available for emergency consultation by telephone Monday through Thursday 8 am to 10 p.m., Friday and weekends 9 a.m. to 7 p.m. If you have an emergency during those hours, please call this office at 503-699-8389; follow the instructions on my answering machine. I will return your call as soon as possible. If for any reason you cannot wait for my return call, or if your emergency occurs outside my emergency consultation hours, please call **Washington County Mental Health at 503-291-9111**, contact your personal physician or go to your nearest hospital emergency room. Telephone consults which are less than 10 minutes will not be charged, those consults which require more time will be charged at my regular rate.

**Initial: _____**

# Financial Policy

**Insurance Plans**

1. My Office Manager will do her best to help you with insurance issues; good communication is the key. It is ultimately your responsibility to understand your benefit plan's covered services, and whether a written referral or authorization is required. Please make sure you know what your copay is, how much of your deductible has been met (if applicable), what your insurance will pay, and whether Dr. Blakeslee is a participating provider on your plan.
2. It is your responsibility to keep us updated with correct insurance information. Please keep us apprised of any changes as they happen. If you neglect to inform us of any changes and billing information, you will be billed and it will be up to you to bill your insurance company.
3. The patient (or guarantor) understands that ultimately the patient (or guarantor) is responsible for payment of any charges accrued. **Initial**: _____

**Financial Responsibility**

1. Participating insurance: If we participate with your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances. ***Copays are due at the time of your appointment.***
2. Nonparticipating insurance: If we do not participate with your insurance plan, we will bill your insurance as a courtesy to you; however, full payment is expected at the time of your appointment until we begin to receive payment from your insurance and know what portion you will need to pay. If you need to work out payment arrangements, please see #6 below.
3. Copays and Deductibles: If your insurance benefit has a set copay per visit, it is ***due at the time of your visit***. If you have not yet met your deductible for the year, it is also ***due at the time of your visit*** unless other payment arrangements have been made (see #6).
4. Children (minors): The parent who brings a child in for appointments is responsible for ensuring copays are paid at the time of service. The guarantor (the insured parent) is ultimately responsible for payment, unless there is a divorce decree stating differently.
5. Payments Due: Patient balances are shown on the statement that will be mailed to you; amounts remaining after your insurance has paid are due within 15 days of receipt of your statement. If that is not possible, please make payment arrangements with us.
6. Payment Arrangements: If you are unable to pay the complete balance after insurance has paid, payment arrangements may be set up by contacting the Office Manager at: billing4drb@gmail.com or calling 503-746-3035.
7. Self-pay: If you are not covered by insurance, full payment of services is ***due at the time of your visit***.
8. NSF Checks: A $30 fee will be charged for checks returned stating insufficient funds.

**Initial: _____**

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*I have read and understand these office policies and agree to comply and accept the responsibility for any payment due. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance. It is also my responsibility to ensure that my insurance has processed all claims to my satisfaction, since ultimately all balances on my account are my own. Even though an insurance claim may be pending, I understand that I will receive a statement of my account if it has an outstanding balance. I further understand that Dr. Blakeslee will not accept responsibility for collecting my insurance claim, and that I am responsible for the timely payment of my account and for all delinquency charges resulting from a failure to pay the account in a timely manner. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.*

*To the extent necessary to determine liability for payment, treatment, and health care operations, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits to which I am entitled to David E. Blakeslee, Psy.D., P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.*

Patient's Name: _____ Date_____

Guarantor's Name (if different from patient): _____