Forward Motion

Layne Hood, CPC, LCSW, 541.390.5373

300 SE Reed Market Rd, Ste #280, Bend OR 97702 (f) 480.247.5521 (e) Layne.Hood@gmail.com (w) www.LayneHood.com

Office Policies, HIPAA Notice, & Informed Consent

Client Name (print): _____ Office use only:

Please read these policies carefully. If you have any questions about them, please ask.

Appointments. Psychotherapy and counseling appointments might vary in length from 30 to 60 minutes but average 45 minutes to best meet your needs. Fees are set by time spent. Your appointment time is held exclusively for you. Please arrive on time to honor yourself as well as your provider's time. If you realize you can't make your appointment, we ask that you provide at least 24 hours notice or you may be charged for that time. Insurance does not pay for missed appointments.

Office Hours and Client Emergencies. I provide services by appointment only Sunday through Friday. We negotiate times that work for both of us. To reach me just call my number. If I am unavailable, leave a message and I will respond as soon as I can, within one day if at all possible. If you need immediate help for a potentially dangerous situation and I am not available, please call 911 or go to the nearest hospital emergency department. If I am away for training or a vacation, either I will still be taking calls or will have arranged for call coverage.

Confidentiality and the Release of Information. All information about you is confidential and will not be disclosed without your written consent except for coordination of medical care. However, I am legally and ethically bound to properly report if 1) I suspect abuse or neglect of a child or elderly person, 2) I believe the client presents a clear and imminent danger to him/herself or to another person, 3) a properly executed court subpoena requires me to testify or provide my records, or 4) an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment. Please note that email and texting are not considered secure and may not be confidential. **Initial: _____**

Online Electronic Health Record, Screening, Progress and Satisfaction Measures. I use an online clinical records and billing system. I also routinely send my clients online questionnaires about their health, symptoms, and our work together. These can be completed on a computer or a Smartphone. This information exchange is secured, confidential, and protected by State and Federal laws. Online questionnaires and electronic health records are common practice in healthcare. You do not have to provide information electronically in order to receive my services. Please tell me if you do not wish to participate or if you have any questions. De-identified information from my practice may be used in research. **Initial: _____**

HIPAA Notice of Policies and Practices. We are required by Federal law (Health Insurance Portability and Accountability Act or HIPAA) and by Oregon 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. I am obliged to share information as needed to coordinate care with your other healthcare providers. **Initial: _____**

Fees and Billing. Initial evaluation and therapy appointment fees may depend on your insurance carrier and other factors. We file claims to most third-party payers. While we prefer cash, check, or swiped card payments for out-of-pocket obligations, we can send electronic invoices for card payments or keep your payment card information on file to use for timely payment. Should you need to carry a portion of your balance, we bill monthly on the 25th of the month. When you receive an invoice, you are expected to make payment no later than the 25th of the next month.

Responsible Party. If requested, we can provide you with a monthly billing statement but only to one household or one responsible part. If two or more people from different households share financial responsibility for a client'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 should complete and sign our billing and office policy forms, after which responsibility for the account can be transferred.

Insurance. Your insurance coverage is a contract between you and your carrier. Any portion not covered is your responsibility. As a courtesy we bill your insurance company and will follow up with them to assist in getting reimbursement for services. However, you are responsible to learn and understand what your insurance covers, optimally before you begin treatment and to track this coverage as treatment progresses. You are responsible for the entire bill whether the insurance pays or not. Your portion is due at time of service unless arrangements have been made in advance with our office.

Information about Insurance Billing. Please make a point to understand how your insurance works. If you have deductible and we bill your insurance, then you must pay us in full until your deductible is met. If we are contracted with your insurance provider, you will not be charged more than our contracted rate with your carrier. You are responsible for your co-pay and any deductible. If you do not wish to bill your insurance, we ask that you make payment at the time of service. We do not bill insurance for you if you have paid for services in full.

If you provide us with health insurance information, you agree to the following: You authorize the release of any health information necessary to process insurance claims for services provided. You authorize your insurance company to pay medical benefits to the provider of services. You authorize payment of government benefits either to yourself or to the party who accepts assignment. You understand that you are fully responsible for all professional fees not covered by this assignment. You understand that payment is due in full at the time of service unless prohibited by my contract with your insurer. We ask that you pay at the time of each appointment. If your obligation is not met at the time of your appointment and you have provided the necessary pay card information, then you authorize the use of your pay card. **Initial: _____**

Responsible Person Signature: _____ Date: _____

Print Your Name Here _____ Rev (01.15.16)