ROGUE MENTAL HEALTH ***SOLUTIONS***

OFFICE POLICY

****Office Hours***

Rogue Mental Health Solutions office hours are Tuesday/Thursday from 10a-4pm and Wednesday and Friday from 8a-5pm. Each individual practitioner's hours may vary. Some early morning and later evening appointments are available.

All appointments are booked through our receptionist in person or by calling our office at (541)770-5100. You will always be seen as promptly as possible. To ensure that you are here on the proper day and time, please check in with our receptionist upon your arrival. ***If you find you must cancel your appointment, we require that you inform us at least 48 hours before the scheduled appointment time in order to avoid a cancelation fee of $50.00. Cancelations for New Patient Evals are required at least 48 hours before the scheduled appointment time in order to avoid the full charge of missed appointment.***

****After Hours***

Rogue Mental Health Solutions is **not** a crisis center. If you are experiencing a life-threatening emergency dial 911 or go to the Asante Rogue Regional Medical Center Emergency Department.

****Prescription Refills***

Please call your pharmacy at least 3 business days in advance when requesting a prescription refill. This will allow enough time for the pharmacy to contact the Prescribing Provider for his/her authorization to refill your prescription. If your prescription is required to be on paper; please allow us 3 business days to complete this for you by calling our office at (541)770-5100. ***Prescriptions and refills are issued during office hours only***. Our providers do not routinely write prescriptions or issue refill requests during the evenings or weekends because your medical records are not available.

****Referrals***

We are proud to offer a multidisciplinary team to handle your mental health care needs. Interoffice referrals are available for medication management and counseling. Ask your provider or our office staff for information on other services provided at our office.

****Contact Us***

Our office is located at 15 Crater Lake Ave Medford, Oregon 97504. Office phone number (541)770-5100. Office Fax number (541)770-5070. Website: rmh-solutions.com

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Patient Signature or Authorized Signature Relationship to Patient

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Printed Name of Patient Date of Birth Today's Date

ROGUE MENTAL HEALTH ***SOLUTIONS***

ACKNOWLEDGMENT AND CONSENT FORM

I understand that Rogue Mental Health Solutions (referred to below as "RMHS") will use and disclose mental health information about me.

I understand that my mental health information may include information both created and received by RMHS, may be in the form of written 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 RMHS may use and disclose my mental health information in order to:

» Make decisions about and plan for my care and treatment;

» Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;

» Determine my eligibility for 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 of my health care; and

» Perform various office, administrative and business functions that support my physicians' efforts to provide me with, arrange and be reimbursed for quality health care.

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

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

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient Signature)

Patient Name: _____ Date of Birth: _____

By: _____Date: _____
(Patient Representative)

Rogue Mental Health ***Solutions***

*****PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED*****

• Insurance Billing

As a courtesy to you we will bill your primary insurance, as well as your secondary, if the appropriate information is provided to us at the time of service. It is ultimately your responsibility to follow up with your insurance(s) to make sure your claim is processed. ***We require co-pays at the time of service***, we are able to accept cash, checks, Visa, MasterCard, American Express and Discover. If we are unable to verify your insurance or you do not present our office with the correct insurance information, you will be responsible for any and all charges incurred. **This office does not bill Medicare or the Oregon Health Plan.**

_____ (initials)

• Self-Pay Patients

Payment is due in full at time of service.

_____(initials)

• Payment Arrangements

If you are unable to pay at the time of the appointment, please contact this office prior to the appointment to make arrangements.

_____ (initials)

• Delinquent Accounts

If you are not able to make payments as agreed and your account becomes delinquent, the account may be turned over to a collection agency. Delinquent accounts are subject to dismissal from our practice.

_____ (initials)

• Divorce Decrees

Minor patients only. CFPC is not a party to your divorce decree. We will not be involved in mediating financial arrangements between parents/guardians. The signed party responsible for the account prior to the divorce or separation remains responsible for the account.

_____ (initials)

• Non-Sufficient Funds

A $35 fee will be added to your account for any checks returned due to a non-sufficient fund (NSF). If we receive a NSF we will no longer accept checks for payment – only cash or Visa/MasterCard. You agree to be responsible for NSF charges even if the check is written by another party.

_____(initials)

• Late Cancels and No-Shows

A minimum fee of $50.00, up to the full price of the appointment for time reserved, may be charged to your account for missed appointments or appointments canceled less than 48 hours in advance. New Patient Evaluations canceled less than 48 hours in advance will result in the patient being charge the **FULL** amount of the appointment missed. Excessive no shows or missed appointments are subject to dismissal from our practice. The above charges will not be submitted to insurance.

_____ (initials)

_____

Patient Signature or Authorized Signature Relationship to Patient

_____

Printed Name or Patient Date of Birth Date

Rogue Mental Health ***Solutions***

ASSIGNMENT AND RELEASE:

I, _____, have insurance coverage with _____ and assign to Rogue Mental Health Solutions and/or the following provider _____, all medical benefits, if any, otherwise, payable to me for services rendered. I agree to be responsible for and to make all payments for services and treatment. **I understand that I am financially responsible for all charges regardless of said charges being paid by insurance.** I hereby authorize Rogue Mental Health Solutions to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions.

X _____ X _____

Printed Patient Name
Printed Guardian Signature

Date

X _____ X _____

Patient Signature
Guardian Signature, Relationship to Patient

Date

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

Group #: _____

Policyholder Name: _____ Date of Birth: _____

Patient's relationship to Policyholder: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Patient's relationship to Policyholder: _____