OLD GEORGETOWN MENTAL HEALTH ASSOCIATES, LLC
POLICIES AND PROCEDURES AGREEMENT

PAYMENT PROCEDURE

Payment is expected at the time of your office visit and checks are preferred.

We ask that you pay your doctor directly. Unless there are questions regarding your bill, please have your payment ready for your doctor before the start of your appointment. This way, we will minimize running late or using session time taking care of collecting fees.

There is a $15.00 charge for all returned checks. A 1% interest charge per month will be added to patient account balances over 60 days

MISSED OR CANCELLED VISITS AND TELEPHONE CONSULTATIONS

Since your appointment time is reserved solely for you, you will be charged in full for missed or cancelled appointments unless the office is notified at least **48 HOURS IN ADVANCE**. (Insurance plans do not reimburse for missed visits.)

Your physician may charge for phone consultations. This includes (but is not limited to): discussion of test results, changes in treatment plans, review of medication doses and side effects and evaluation of new medical issues. Some insurance companies do cover these fees. If your insurance company does not, this fee will appear as a balance on your statement.

HMO/PPO MEMBERS

Be sure to clarify whether your doctor participates with United Health Care. We do not participate with Medicare or any other insurance plans.
Co-payment is expected at the time of each visit. Referral forms and Insurance forms are your responsibility. Please provide them so services can be rendered. Please be advised that you will be responsible for any visit for which you have not obtained the appropriate referral.

PARKING

We do not validate parking.
You may park in the garage at no extra charge. There are frequently available spaces in the garage on the lower level or the 3rd and 4th levels. The elevator is at the end closest to the Suburban Outpatient building.

Please advise our office of any changes in insurance coverage, address, or phone numbers.

Your signature indicates that you have read and understand this agreement. We appreciate your cooperation.

_____ _____
Patient/client signature Date

Old Georgetown Mental Health Associates, LLC

Patient Consent to the Use of Protected Health Information

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my private health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at 10215 Fernwood Road, Suite 520, Bethesda Maryland 20817 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient
Name:_____Signature:_____

Relationship to
Patient:_____Date:_____