Heron Mental Health, PLLC
509 Olive Way, Ste 204, Seattle, WA 98101
Phone: (206) 329-5255 x317
Fax: (206) 726-1878

SERVICES AGREEMENT

Thank you for choosing Linda Corey, ARNP for your mental health care. I appreciate the opportunity to provide you with professional services including psychiatric evaluation and medication management.

Please read the following information regarding my office policies. Your signature signifies that you have read, understand, and agree to abide by these policies, and that you have received a copy of these policies for yourself or declined a copy. You have the right to revoke the Services Agreement in writing at any time. I will consider your written revocation request as binding except in the following circumstances. These are (1) if Linda Corey, ARNP has taken action in reliance on the agreement and (2) you have not satisfied financial obligations incurred with Linda Corey, ARNP.

Client's Rights:

- You have the right to refuse treatment.
- You have the right to change practitioners or receive referral to another practitioner.
- You have the right and responsibility to choose a practitioner that best suits your needs.
- You have the right to confidentiality. There are exceptions for the reporting of abuse as required by law, dangerousness to self or others, or grave disability. I will provide you with a "Notice of Privacy practices" at your first appointment.
- You have the right to raise questions about my therapeutic approach or your progress at any time.

Appointments:

Our first appointment together will last for approximately 60 minutes. This is an opportunity for us to get to know each other, for me to be able to assess your needs, to answer your questions, and in most instances, to collaboratively develop a plan of care. Sometimes more than one appointment is necessary to conduct a full assessment and make treatment recommendations. Please bring your insurance card and state issued

identification to this appointment. Follow-up visits for medication management generally last 10-25 minutes but can be longer depending on educational needs, the complexity of treatment, and other factors. The frequency of appointments is determined on an individual basis depending on the response to medications and severity of symptoms. New medications are not prescribed, nor are doses changed, over the phone.

Fees:

Initial evaluation: $250-400 depending on length of time and complexity.
Brief medication management visit (10-25 minutes): $110-$140
Extended medication management visit (longer than 25 minutes): $140-$275 depending on length of time and complexity.

Low income individuals without insurance, paying with cash or check at time of service:
Initial evaluation: $225
Medication management (10-25 minutes): $90
Extended medication management visit (longer than 25 minutes): $140-$175 depending on the length of time and complexity.

Telephone calls in excess of 5-10 minutes will be charged on a prorated basis. Insurance companies do not reimburse for telephone calls. There will be a $25 charge on all returned checks.

Payment and insurance:

I am a preferred provider for Regence Blue Shield and Premera Blue Cross and will bill these providers directly. If you are not covered by one of these plans, please keep in mind that you may still be able to use your insurance if your plan has out-of-network benefits. If using these benefits, you will be responsible for payment in full and then requesting reimbursement from your insurance company. I cannot accept clients who are Medicaid or Medicare due to their billing rules. It is advised that you contact your insurance company to confirm that Linda Corey, ARNP is available to you under your specific plan and to obtain information, such as expected co-payment amounts and deductibles.

Because of the high number of clients who don't pay for their services, I require a credit card number to be on file. For clients covered by Regence and Premera, this will be applied to deductibles, copayments, and no-shows or appointments cancelled with less than 24 hours notice. For all other clients, this will be used to pay for the full cost of services and for no-shows or appointments cancelled with less than 24 hours notice. Insurance

reimbursement is a contract between you and your insurance carrier. I cannot accept responsibility for collecting on a disputed insurance claim. You are ultimately responsible for full payment on your account.

The staff of the billing office and can be contacted to answer your questions about your bill by phone at (206) 726-1790 or by visiting the billing office. You may leave a message on their voicemail at any time.

Cancellation/missed appointment policy:

Please notify me at least 24 hours before cancelling a scheduled appointment. Cancellations with less than 24 hours notice or missed appointments will be charged $100.00.

It is necessary to start and end appointments on time. I will do all that I can to keep appointments on schedule. In the event that you are late for an appointment, please note that we will not be able to run past your scheduled time. If you are 10 or more minutes late for a medication management appointment, this will be considered a missed appointment. If you are 15 or more minutes late for an initial evaluation appointment this will be considered a missed appointment. I do understand that there are some circumstances that are beyond your control and a missed appointment fee may be waived at my discretion. Please note that insurance plans do not pay for missed appointments. These charges will be entirely your responsibility.

Emergencies:

I check my voicemail frequently, and will return your calls as soon as possible. In the event of an emergency, my voicemail has instructions on how to page me. If for any reason, you do not get a call back and you need to speak with someone right away, please call the Crisis Clinic at (206) 461-3222. If this is a medical emergency call 911 immediately or go to the nearest hospital emergency room. In my absence, I will leave the phone number of a colleague on my voice mail. I will authorize my colleague to access your records in the event that you have an emergency or need a prescription refilled.

Credentials and Licenses:

I am licensed by the State of Washington as a Registered Nurse (R.N.) and Advanced Registered Nurse Practitioner (ARNP) with prescriptive authority. Prescriptive authority means I am licensed to prescribe medications within my specialty and scope of practice. I

hold a Master of Science in Nursing, and I am board certified by the American Nurses Association Credentialing Center as a nurse practitioner in Family Psychiatric-Mental Health Nursing. I belong to the Association of Advanced Practice Psychiatric Nurses. As a licensed professional, I am accountable for my work with you. Should you feel that I have been unethical or unprofessional, please talk to me about it. If you are unable resolve your concerns about me, you may contact the Department of Health, Nursing Care Quality Assurance Commission Complaint Intake, Post Office Box 47864, Olympia, Washington 98504-7864. The phone number is (360) 236-4739.

About Associates in Behavioral Health, PLLC: (ABH)

Associates in Behavioral Health, PLLC (ABH) is the name of the legal corporation owned by the psychologists, psychiatrists, and nurse practitioners that comprise this practice. Although I share office space and expenses with others, we are each sole proprietors in our own practices. I am not responsible or liable for the practices of any other practitioner in my building nor are they responsible or liable for my practices and procedures.

Agreement to participate in services and consent for care:

After reading these policies and the Notice of Privacy Practices, please sign the following page. Your signature indicates that you understand my policies and agree to abide by its terms. It also serves as and acknowledgement that you have received and read the Notice of Privacy Practices form. Please submit this signed statement to me at our first appointment. You may wish to keep a copy for your records, as you may need to reference it in the future.

Patient Name: _____

AGREEMENT TO PARTICIPATE IN SERVICES AND CONSENT FOR CARE

Disclosure law requires Heron Mental Health, PLLC to obtain your signature acknowledging that we have provided you with this information. Your signature below indicates that you have read or listened the information in this Services Agreement and in the accompanying handouts, that you understand it and agree to abide by its terms during your professional relationship with Heron Mental Health. It also serves as an acknowledgment that you have received and read or listened to the Notice of Privacy Practices form and the current fee schedule. If you have any questions, please feel free to discuss them with me before signing this Services Agreement. Your signature indicates you accept responsibility for payment of fees in accordance with these terms and conditions.

These policies may be updated at anytime.

I hereby authorize Heron Mental Health, PLLC and/or Linda Corey, MSN, ARNP to provide mental health services including evaluation and treatment, or providing consultation.

This agreement constitutes informed consent without exception.

Patient signature _____ Date _____

Heron Mental Health, PLLC
Linda Corey, ARNP, its Member