TRUE NORTH
Clinical Associates

AN ASSOCIATION OF INDEPENDENT PRACTITIONERS

CLIENT-PRACTICE POLICY AGREEMENT

Welcome to our office! We are happy to have you here, and ask that you take a moment to review the information that follows to familiarize yourself with our practice. Most of the questions that you may have will be answered in the information that follows, but if you have any other questions at all, please let us know.

CONSENT FOR TREATMENT: True North Clinical Associates, LLC is a practice made up of like-minded but individually practicing and individually licensed mental health professionals. Managing partners Dr. Paul Mullen and David Torres, LCSW are joined by the associated clinicians below. You will receive treatment from these individuals only; True North will not provide clinical services. Payments should be made directly to and billing statements will issue from the individual practitioners.

I acknowledge and understand that, in presenting myself for treatment and continuing medical care with the clinician(s) indicated below, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the clinician(s) checked below (and/or designated assistants) and carried out by members of the staff and personnel. Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

Dr. Paul Mullen & Associates

- □ Paul J. Mullen, Psy.D.
- □ Jacey Keeney, Ph.D.*
- □ Susan Pollard, LCPC
- □ Stacey Sanicki, LCPC
- □ Madelyn “Dede” Schwartz, LCPC
- □ Marc Anderson, LCSW
- □ Sue Taddeucci, LCSW
- □ David Torres, LCSW

*supervised by Dr. Paul Mullen

APPOINTMENTS: Successful on-going therapy requires a commitment on the part of the patient and the clinician. As such, it is important that you keep your appointments. If you are unable to keep your appointment or are going to be late, please call our office as soon as possible to inform us. This courtesy allows us to make the time available to other patients. Missed appointments or cancellations without a twenty-four hour advance notice will be assessed a cancellation fee of $75.00.

APPOINTMENT CONFIRMATION: Upcoming appointments will be confirmed by phone or email inadvance of the session. Please provide an email address below where you wish to receive your confirmations.

- □ Please send confirmation emails to: _____.
- □ Please do not send confirmation emails.

PAYMENTS/CO-PAYS: Payment is required at the time of service for any current or past due balances unless other arrangements have been made. This includes co-payments, missed appointment fees, co-

insurance, or any balances that are the responsibility of the patient or the patient's guarantor/insured. Payment may be made by cash, check, *Visa, Mastercard, or Discover*.

THERE WILL BE A CHARGE OF $25.00 FOR ALL RETURNED CHECKS.

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to the Clinician. I understand and agree that this agreement constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of such costs, charges, or expenses by any third party or a divorcee party, and assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Clinician's right to require direct payment from the undersigned. The Clinician expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

With regard to payment, I authorize Clinician to release medical information or copies from my medical record including mental health and/or substance abuse within a 1 year time frame to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers' insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked at any time.

INSURANCE: The Clinician and/or their designated billing professional is/are responsible for filing all contracted insurance claims for patients. The associates of True North are contracted with and only accept Blue Cross/Blue Shield PPO**.** If you have any questions regarding your benefits, it is your responsibility to contact your insurance company for clarification. All patients are responsible to obtain authorizations from their insurance company if required by their policy. If your insurance company denies the payment for any reason, you will be responsible for the payment. If you are covered by any insurance other than Blue Cross/Blue Shield PPO, you will be considered a fee-for-service client and full payment will be due at the time of service. You may then file with your insurer for out-of-network benefits. All out-of-network claims are to be filed by the patient. Our office will provide you with the necessary paperwork for such filings.

By signing below, I authorize the Clinician to submit claims to Blue Cross/Blue Shield and to obtain any information applicable or required for treatment. I further assign, transfer and set over to the Clinician (and the billing service of the Clinician), all rights, title and interest to medical reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all rights, title and interest as beneficiary of the ERISA plan to the Clinician, with regard to your treatment and care with this practice.

TELEPHONE CALLS: Time spent with you on the telephone by your therapist outside of appointments scheduled may be charged at the pro rata hourly rate. These charges will be assessed at the discretion of the individual clinician.

PRIVACY PRACTICES: The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard from certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and

information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships (e.g. billing services, answering services, etc) and may have to disclose personal health information for the purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I acknowledge that I have been provided information on the standards for privacy of individually identifiable health information. I understand that I may request a copy of these privacy practices in their entirety at any time.

My signature below indicates that I have read all 3 pages of the Patient-Office Policy Agreement and that I understand and agree to the policies contained herein. This shall serve as my signature for all documentation related to my treatment at True North Clinical Associates and shall be valid throughout the duration of my treatment.

_____

Patient Name (Printed)

_____ _____

Patient Signature **Date**

_____

Guardian Name/Relationship (if applicable)

_____ _____

Guardian Signature **Date**