PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239

PHONE: (503) 231-7854 **FAX: (503) 231-8153**

GUARANTOR POLICY

Client Name: _____
Person and/or Agency Financially Responsible: _____
Guarantor DOB: _____ Guarantor SSN/Tax ID: _____
Billing Address: _____ City/State: _____ Zip: _____
Phone Number: _____

I, _____by signing below, acknowledge that health care services provided by Portland DBTI for the above named client will be covered by the insurance company/payor known as _____. As a member and/ or designated representative of this company, I/we agree to the following financial policy:

In the interest of a cooperative working relationship between Portland DBTI, clients, and payors, please carefully read our financial policy as described below. If you have any questions or concerns regarding this policy, we encourage you to speak with the client's therapist.

Client Membership Fees and Out- of -Pocket Expenses:
Client out-of-pocket expenses such as membership fees, deductibles, co-payments, and co-insurances are due at the time of service. All clients in EST or comprehensive DBT treatment are considered members of our program. The membership fee is due at the time of group registration. Clients with the Oregon Health Plan or Kaiser HMO plans are not required to pay the membership fee as a benefit of their coverage. A credit card authorization form must be signed prior to treatment for all outstanding balances (clients with OHP coverage are excluded from this requirement).
Initial_____

Insurance Billing: As a courtesy to clients, we will bill your primary insurance for services rendered providing you submit all the necessary information enabling us to do so. Please be aware that no-show/late cancellation fees and parent skills group sessions are not billed to insurance and are due by the client on or before your next scheduled appointment.

Secondary Insurance: We do not bill secondary insurance. However, we will be happy to provide you with a statement for your secondary insurance company should you wish to recover your out-of-pocket expenses directly from them.

Insurance Delinquent Balances: We consider it our responsibility to provide clients and their families with quality care. In exchange, we ask that clients work with their insurance companies to compensate us in a timely manner for services rendered. While we do our best to collect on all insurance claims, in the end, we cannot accept responsibility for continued follow up on past due claims or negotiating a disputed claim. Thus, we require that insurance balances past due by 90 days and/or equal to or greater then $2000.00 be paid by the client in full in order to continue services. Clients in the Eating Disorder Intensive Outpatient Program (ED IOP) may not have an outstanding insurance balance over $9000.00 (22 days of services). You will be given adequate notice and referral options should your treatment at PDBTI be postponed until delinquent insurance balances have been resolved.
Initial_____

Client Delinquent Balances: Client balances (not owing by insurance) are due in full within 30 days of receiving your monthly statement. During treatment, clients that have patient balances exceeding $500.00 must be paid in full in order to continue receiving services. You will be given adequate notice and referral options should your treatment at PDBTI need to be postponed until delinquent patient balances have been resolved. Please be advised

that accounts past due by 90 days, unless payment arrangements have been made with the billing department, may be sent to collections. As a courtesy to clients, a collections warning letter is sent indicating the status of your account. You will be given 10 working days to respond to this notice before action is taken. If you discontinue treatment at any time and your account is delinquent or assigned to collections, you will not be allowed to come back to the program until your balance has been paid in full. Further, if you name PDBTI as a debtor when filing bankruptcy you will not be able to return for services. **Initial_____**

Client Refunds: Client refunds are issued the 15th of every month once your account has been cleared. In other words, even if you have money on account, refunds will not be issued until after your insurance has paid in full.

Receipts: Receipts will be provided at the time of payment. We recommend that you maintain a record of your visits and payments for any reimbursement that your employer or others may require.

Returned Checks: There is a $25.00 processing fee on returned checks. We require that your returned check amount plus the processing fee be paid in full on or before your next scheduled appointment.

OHP Clients: Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. However, if an OHP client's insurance balance is past due by 90 days and/or is equal to or greater then $2000.00 ($9000.00 for ED IOP services), treatment may be interrupted until the insurance problem has been resolved.

Signing below indicates 1) I have read Portland DBTI's financial policy, 2) I understand Portland DBTI's financial policy, and 3) I agree to Portland DBTI's financial policy.

Financially Responsible Party:

Name: _____ Relation to Client: _____

Signature: _____ Date: _____

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PORTLAND DBT INSTITUTE, INC: AUTHORIZATION OF DEBIT/CREDIT CARD

Cardholder Name: _____

Date of Birth: _____ Phone: _____

Street Address: _____

City: _____State: _____ Zip: _____

CREDIT CARD #: _____
(Visa or MC *only*)

EXP. DATE: _____

Please attach a copy of the front and back of the card.

I, _____ authorize Portland DBT Institute, Inc to charge the credit card as named above for health services rendered to _____.

Services that may be charged to this credit card include, but are not limited to the following:

- Mental Health Assessment
- Individual Therapy
- Family Therapy
- Group Therapy
- Parent Group
- Med Management
- Nutrition Management
- Case Management Services
- Intensive Outpatient Services
- Consultation
- Missed Session
- Co-pay
- Deductible

Charges will be made at the time of service or monthly for balance due. This agreement will expire after treatment is terminated and no further charges are incurred.

_____ _____
Cardholder Signature Date

_____
Cardholder Printed Name

Portland DBT Institute, Inc
5200 SW Macadam Ave, Suite 580
Portland, OR 97239
Voice: 503-231-7854 Fax: 503-231-8153

Therapist: _____

___ DBTI is **SENDING** Records
___ Keep Release on **FILE** for Future Use
___ DBTI is **REQUESTING** Records

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) _____ authorize the use and disclosure of my individually identifiable health information to/from:

_____

Person and Agency Represented (if applicable)

_____

Address and Phone/Fax Number

B. Purpose of Disclosure: Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

____Assessment/Treatment/Coordination of Care ____Eligibility Determination ____Legal/Court/Corrections/Probation
____At the request of the client ____Other: _____

C. Specific Information to be Disclosed: By **initialing** next to a category listed below, I specifically authorize use of confidential information.

____ Psychiatric and Mental Health information as included in the records.
____ Alcohol and Drug Treatment information (Specifically protected under law) _____
____ AIDS/HIV/ other STD testing information (Specifically protected under law)
____ All health information about me as described above, *excluding* the following: _____
____ Specific health information including only: _____
____ Mail records certified if indicated by Portland DBTI

D. I give permission to release my records from the following dates:

_____ _____
(approximate start date of treatment from provider above) (approximate end date of treatment from provider above)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, CFR 42 Part 2, RCW 71.05, 70.02, 71.34,74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and can not be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonably needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Portland Dialectical Behavior Therapy Institute.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization.

Date _____ Signature of Client _____

Print Client's Full Name _____

Client's Birth Date _____ SS#: _____

Date _____ Signature of Parent/Legal Representative* _____

*When client is not of legal age or competent to give consent, the signature of Parent or Legal Representative:

F. Redisclosure: If you give us permission to share your information with others, they may share your information without your consent. We cannot ensure that your information will be protected by others. However, some instances of State and/or Federal law may protect your information from being shared with others if it is information about HIV/AIDS, mental health, genetics, or drugs/alcohol.

G. Information about treatment, payment, and insurance: If your written permission to release health information about you is needed to determine your eligibility for medical programs and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us written permission to release your information to them, then we may not provide you with that health care service.

To the recipients of protected health care information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.