



PORTLAND DBT INSTITUTE, INC
5100 S MACADAM AVENUE, STE 5350 PORTLAND, OREGON
97239 PHONE: (503) 231-7854 | FAX: (503) 231-8153

GUARANTOR POLICY

Client Name: _____
Person and/or Agency Financially Responsible (i.e. Guarantor): _____
Guarantor DOB: _____ Guarantor SSN/Tax ID: _____
Billing Address: _____ City/State: _____ Zip: _____
Phone Number: _____
Guarantor email for receiving electronic statements: _____

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. You will be required to pay the balance remaining after your primary insurance has paid. Please be aware that no-show/late cancellation fees and Parent and Caregiver skills group sessions are not billed to insurance and are due by the client on or before your next scheduled appointment.

Secondary Insurance: If your provider(s) at PDBTI are in-network with your secondary and/or tertiary insurance plans, we will bill them as well and you will be required to pay any remaining patient balance. We will not bill secondary and/ or tertiary plans where we are out-of-network, however we will be happy to provide you with a statement should you wish to recover your out-of-pocket expenses directly from your insurance plan.

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 than \$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 than \$2000.00 (\$9000.00 for ED IOP services), treatment may be interrupted until the insurance problem has been resolved.

Signature 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:** _____

Paper Statements: Statements are by default sent electronically only. If you would like to opt in to mailed statements, please complete the fields below. This is entirely optional. If you do not complete this section, statements will be sent electronically.

[] I would like to receive **paper copies of billing statements** to the mailing address specified below.

Street address: _____

City: _____ **State:** _____ **Zip:** _____



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AUTHORIZATION OF DEBIT/CREDIT CARD

Cardholder Name: _____
Date of Birth: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____

CREDIT CARD #: _____
EXP. DATE: _____

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

I, _____, authorize Portland DBT Institute, Inc to charge the credit
(Cardholder name)
card as named above for health services rendered to _____.
(Client full name)

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 and Caregiver 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