

KATE BLUMNER MD, LLC

1600 SE Bybee Blvd, Suite 200, Portland, OR 97202 • tel: 971-229-0269 • fax: 971-229-0617

Practice and Financial Policy Information

Please review the following information carefully and sign the form to indicate that you have reviewed and understand all of the information and agree to these terms in our work together.

Phone and Emergency Contact:

I respond to phone messages between Monday and Friday and return calls as soon as possible. For non-urgent matters, it may take 1-2 business days for me to return your call. For urgent matters I am available by cell phone and will do my best to respond as quickly as possible. If you need to reach me urgently you may leave your name and number on my cell phone at 971-270-2419. Please note that I am not able to provide emergency services. If you are in need of an immediate response or are in an emergency you should call 9-1-1 or the County Crisis Line (503-988-4888 in Multnomah County) or seek care in a nearby Emergency Department.

Cancellations:

Psychodynamic psychotherapy is a treatment method that benefits greatly from consistent and regular appointments. As part of your treatment, I offer regularly scheduled appointments as much as possible. I will make every effort to notify you ahead of time when I am not able to keep a scheduled appointment.

There will be no cancellation fee for the first four missed or cancelled sessions of the calendar year for those in weekly treatment. There will be a charge of \$200 per session for further missed or cancelled appointments. For those with more than one regular session per week, a total of three weeks of sessions can be missed annually before charges accrue (e.g. six sessions for patients seen twice weekly).

Occasionally I am able to reschedule a missed or cancelled appointment. If an appointment is rescheduled, that visit will not be counted as missed nor accrue any fee. Holidays, inclement weather leading to school closures, and my own planned or unplanned absences will not count towards cancelled or missed visits. Advance notice of cancelled visits is appreciated and will improve my availability for rescheduling.

I am not able to bill insurance companies for cancelled or missed appointments. Any cancellation charges will need to be paid in full at the following session. If there are special circumstances around your schedule, I invite you to discuss them with me directly. For patients seen on an occasional basis, there is a cancellation policy of 2 business days with a missed visit charge of \$200 per session for appointments missed or cancelled without sufficient notice.

Length and Frequency of Sessions:

I provide individual psychiatric and psychotherapy sessions lasting 45 minutes each. The duration and frequency of treatment will vary depending on your needs and concerns. Sessions will begin and end on time. If you are not on time to your appointment, our session will be shortened by the amount of time you are late, without any reduction in fee. If I am not able to start the session on time, I will attempt to extend your session when possible to the full 45 minutes.

Parking:

Street parking only. There is no building parking available.

Fee Policies:

Fees are payable in full at the time of each visit unless there is a billing arrangement made, in which case the balance should be paid in full within two weeks of receipt. If I am an in-network provider with

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your insurance, I will bill your insurance directly and you will only be required to pay your co-pay at the time of service. However, if I am not in-network with your insurance you may need to pay my full fee at the time of service. Regardless of your insurance coverage, you alone are responsible for paying your bill including co-pays, any portion of your account not covered by your insurance, late payment billing charges and missed appointment fees. Your insurance company is not responsible for these charges or your balance. Fees may vary depending on severity or complexity. Feel free to discuss any questions about my fees with me directly. Please be advised that any uncollected fees may be turned over to a third party for collections and that this third party may be notified of the reason for service (mental health treatment). I will work with you to avoid this happening whenever possible.

Limitations:

I do not participate in disability applications or assessments. I do not provide assistance with any health, life, disability or mortgage insurance policy applications or assessments. If you or a third party requests me to write any documents regarding your care, diagnosis, or treatment plan, the hourly psychotherapy rate will be charged for the time it takes me to complete the requested document.

Informed Consent:

I have read and understand the above office practice and financial policy information. I have had an opportunity to ask questions about the terms described and I agree to them without exception.

Printed Name: _____

Signature: _____

Date: _____