Nancy L. Hamlin, ARNP, PMHNP-BC
1728 West Marine View Drive Everett, WA 98201-2094
P) 425.252.9216 F) 425.252.8637

Client Information

Please fill out to the **best of your knowledge.**

Date:_____

Client Name:_____

DOB:_____ **Age:**_____ **Gender:**_____

SSN:_____ (Adult clients only)

Home phone:_____ ☐ Preferred

Cell Phone:_____ ☐ Preferred

Other:_____ ☐ Preferred

E-mail:_____

Address:_____

Parent or legal guardian:_____**DOB:**_____

SSN:_____ **Relationship:**_____

Emergency Contact:_____**Relationship:**_____

Phone #:_____

☐ I routinely share information with all providers involved in your medical care. Please **initial this box** if you agree they be contacted with your medical information that you share with me in a treatment plan.

Primary Care Physician:_____

Location/clinic:_____**Phone:**_____

Other provider/Specialty:_____

Location/clinic:_____**Phone:**_____

Pharmacy:_____**Location** (City):_____

Phone #:_____

Referred by:_____

Office Policies and Procedures

Commitment to change:
An effective treatment program requires openness, commitment to change, and an attitude of collaboration between the client and provider. Since many of the aspects of these requirements are intangible and the response to medications and therapy is variable, the degree of success of any treatment or therapy cannot be fully guaranteed.

Limits of confidentiality:
All communications between the provider and the client are confidential. Both verbal and written records regarding a client will not be shared with another party without written consent from the client or the parent or legal guardian of the client. By law, there are exceptions to this policy. As noted below are those exceptions.

Coordination of Care:
To support comprehensive care and to prevent unintentional, adverse treatment combinations, records will be shared with other providers involved in the care of the client. If this is not allowed, the initial consultation summary will not be shared. Depending on the circumstances, ongoing care may not be provided.

Duty to warn and protect:
In the event a client discloses his/her intentions or plans of harming another person, the provider is required to report this information to legal authorities and/or warn the intended victim. If the client discloses or implies a plan for suicide, legal authorities will be notified and reasonable attempts will be made to contact/notify the family.

Abuse or neglect of children and vulnerable adults:
If a client discloses or suggests that he/she is currently or recently has abused a child or vulnerable adult, the provider is required to notify legal authorities. If the client discloses or suggests that they, the client have been abused or neglected, it is the duty of the provider to notify legal authorities.

Prenatal exposure to alcohol and controlled/illegal substances:
As a healthcare professional, the provider is required to report any admitted or suspected exposure of alcohol and/or controlled/illegal substances during gestation.

Court orders (subpoena):
If the records of the client are subpoenaed by the courts, the provider is required to disclose all information that has been requested.

Other provisions:
When fees for services are not paid in a timely manner, collection agencies may be utilized in an attempt to collect any unpaid debts. Client/Provider communications (written and verbal), will not be disclosed during this process. For more information regarding our payment policies, please refer to the attached financial policy form and/or the "Payment Policy" section of this packet.

Insurance companies and third-party payers:
In order to provide adequate care and to ensure coverage for services, we are sometimes asked to disclose any records and pertinent information that has been requested by the client's insurance company. Information which may be requested/disclosed includes the types of services, dates/times, treatment, diagnosis, description of impairments, progress in therapy, case notes, and summaries.

Family members and friends:
In order to protect the client's privacy, any calls made from outside sources will not be returned unless we have a signed release of information on file.

Ethics and professional standards:
Your provider, Dr. Nancy Hamlin is licensed and certified in the specialty of advanced psychiatric nursing. If you have any questions and/or concerns about the course of treatment, please discuss them with your provider. Should you feel that your provider has been unethical and/or unprofessional, you may contact the licensing department of Olympia.

** For detailed information please refer to the attached Fee Schedule/Financial Policy**

Please initial here after you have read and understand this portion of the policy:

Payment for Services

- All payments are due at the time of service. This includes co-pays, deductibles, co-insurances and any out of pocket expense for those clients without insurance coverage. **In the event that a co-pay is not collected at time of service a $10.00 charge will be added to your monthly statement.**
- This office reserves the right to send a bill to collections after 90 days of non-payment. Any questions regarding payments need to be directed to the billing department.
- Payment arrangements are available under the discretion and prior approval of the provider. It is understood that financial hardships may make paying your account difficult. We are willing to work you towards bringing your account up to date. You are advised to discuss any such arrangement with the clinic's billing manager.

Insurance Coverage:

- As a courtesy, any and all insurance claims will be processed by the billing manager.
- Should your insurance company deny your claim and refuse to pay or if any insurance claims are left unpaid after 30 days of being billed, the financially responsible person for the account will be held liable for any balances until the account is paid in full.
- Per the health plan, some insurance companies require pre-certification/authorization for treatment. It is the responsibility of the client to obtain any such authorization before the scheduled appointment. The biller will do her best to let the client know if this is required.
- ***It is highly recommended that you read through your insurance handbook to better understand your health plan and policy. This clinic is not responsible for knowing this information.***

Forms and Letters:

- If you require paperwork to be completed, you must schedule an appointment. (Co-pays, co-insurances and deductibles will apply)
- No paperwork will be completed outside of an appointment without the prior knowledge and consent of the provider.
- Any forms/letters completed outside of an appointment are subject to the availability of the provider and will result in a fee.

Initial Evaluation (75-90 minutes):

- For the sole purpose of the initial visit, a credit number must be obtained in order to hold the appointment. In the event of a no-show or late cancel to this appointment we will run the card for the amount of **$351.00.** In order for the provider to bill and receive payment for services provided, the client MUST be in attendance to all scheduled appointments.
- The CC # is only required for the security of the first visit. Any and all future appointments that are missed or canceled with less than 48 business hours of notice are subject to the "No-Show/Late Cancel" charge noted on the fee schedule.

A client is subject to be discharged from services in the event of:

- 2 or more No-shows and/or late cancels to appointments.
- Inability to make appropriate payments on outstanding accounts.
- Inability to follow the agreed upon treatment plan and/or the misuse of prescription medications.
- Display of inappropriate behavior toward the office staff and/or the provider.

In addition, we routinely discharge clients who have not been seen in a period of 8 or more months who do not have a follow-up appointment on the schedule. Depending on the circumstances, we may agree to take the client back and continue services.

I authorize Nancy L. Hamlin to release any information necessary to my insurance company to expedite insurance claims. I hereby assign all insurance benefits to Nancy L. Hamlin. I understand that I am responsible for all charges, regardless of insurance coverage.

I have read and understand these terms of payment for service:

_____ _____

Client signature: (if 18 or older) **Date:**

_____ _____

Parent or guardian signature (if applicable) **Date:**

_____ _____

Print Name (if applicable) **Relationship to client**

Please initial here after you have read and understand this portion of the policy: _____

Cancellation Policy:

- If you are unable to keep your scheduled appointment, please notify the office within 48 business hours, EXCLUDING WEEKENDS & HOLIDAYS, of the appointment. Any appointments that are not kept or that have been canceled with less than the required 48 business hours of notice are subject to a fee. A bill will be sent to the person who is financially responsible for the client's account.
- We understand that personal schedules and obligations may interfere with the client being able to attend his/her appointment, but the time slot has been saved for that client. It is the responsibility of the client to notify the office if he/she is unable to attend their scheduled appointment. *Note: Under HIPPA, ONLY YOU can cancel your own appointment. Any cancellations by others are not valid. This is for the purpose of protecting your confidentiality.
- If the client should arrive more than 15 minutes late to their appointment, it will be considered a "NO-SHOW" and a fee will be changed to the account.
- We make every attempt to see each client at their scheduled time, but due to the nature of this practice, we cannot predict the outcome of each appointment. In the event the provider is running more than 30 minutes behind and the client is unable to wait, we will reschedule the appointment at no charge to client.

Phone calls and voicemails:

Adult clients are expected to communicate on their own behalf regarding any need for services such as scheduling and/or canceling an appointment, medication questions and/or concerns or billing/payment questions. Unless allowed by a release of information signed by the client, no communications can be accepted from any third party on behalf of the client. No exceptions will be made to this policy due to confidentiality and accountability requirements.

- We make every attempt to answer the phone during business hours. If you are unable to reach the front desk, please leave a brief voicemail. The voicemail boxes are checked periodically throughout the day. (Monday-Friday).
- Return calls will be made within **72 business hours**.
- Changes to medication cannot be determined over the phone or by e-mail unless previously discussed and documented at an office appointment. We will do our best to find the next available appointment in which to discuss these changes.

Emergency availability:

Emergencies are defined as "life-threatening" problems that cannot wait to be resolved on the next working day. If an emergency should occur after the regular working hours, you are advised to call 911 or visit your local emergency room as soon as possible. The care crisis line is also available by dialing 211. Urgent issues are considered to be situations which cannot be dealt with via telephone conferences. Appointments can be made to discuss any questions and/or concerns that cannot wait until the next scheduled visit. Please be advised that it may take up to 24-72 business hours to find an available opening for any such appointment.

Holidays & Vacations:

This office recognizes the following holidays:

1) New Year's, 2) Memorial Day, 3) Independence Day, 4) Labor Day, 5) Thanksgiving Day, 6) Christmas Day

- If these holidays should fall on a weekday, they will not be considered a business day.
- In addition to these holidays, the provider takes time off for personal vacation time and for business conferences that she is required to attend. In the event this should happen, we will do our best to notify all clients as much in advance as possible.
- During these times, the front desk will be available for phone calls. Dr. Hamlin will be available by e-mail. Please be advised that only the provider can approve medication requests. Should the provider be unavailable to approve these requests, we ask that you send your requests in advance to allow for this wait period. Please refer to the medication policy for more information on this policy.

Consent for treatment:

This authorization constitutes informed consent without exceptions and allows Nancy L. Hamlin to provide the treatment and diagnostic procedures as they become advisable. I understand that the purpose of these procedures will be explained to me and they are subject to my agreement. I understand that while my treatment is designed to help, there are no guarantees on the outcome.

I have read and understand the above agreement.

Client signature: (if 18 or older)	**Date:**
Parent or guardian signature (if applicable)	**Date:**
Print Name (if applicable)	**Relationship to client**

Medication Prescriptions and Refill Policies:

In order to effectively manage your medications, please be aware that the following guidelines MUST be followed:

1. Requests for refills may take up to 3 business days to complete. We ask that you e-mail Dr. Hamlin for these requests If you do not have e-mail you may have your pharmacy fax a request no less than 10 days BEFORE you are out of your meds.
2. It is the responsibility of the client to keep track of their medications and when refills are needed.
3. The client MUST have an appointment on the schedule BEFORE any requests will be approved.
4. Any requests received for a client with no follow up appointment will be returned to the pharmacy denied.
5. It is the responsibility of the requesting pharmacy to inform the client of a denial and its reason.
6. We need to be notified immediately of any side effects to your medications.
7. We need to be notified as soon as possible of any additions to your medications that have been made by another provider.
8. Be aware that some medications may not be covered or allowed by your insurance company. In which case a "medication prior authorization" can be done. This does not ensure the medication will be approved, at which time a different medication can be discussed.
9. A "controlled substance agreement" must be signed by all clients who are prescribed controlled substances such as benzodiazepines or stimulants.
10. Any requests made to expedite a medication refill are subject to a fee. Please refer to the attached fee schedule for more information regarding this matter.

I have read and understand the medication prescription and refill policy set in place by this office.

Client signature: (if 18 or older)	**Date:**
Parent or guardian signature (if applicable)	**Date:**
Print Name (if applicable)	**Relationship to client**

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FINANCIAL POLICY

Client name:_____ **DOB:**_____

Prices stated as full fee and subject to change. ** Some fees may not be reimbursed by insurance

Psychiatric diagnostic interview (evaluation)	**90792**	$ 351.00 **full fee charge if "no show" occurs**	90 minutes
Medication management only	**99213**	$ 146.50	15 minutes
Medication management w/ brief therapy	**90833**	$ 236.00	30 minutes
Psychotherapy session w/ med management	**90836**	$ 276.00	60 minutes
Psychotherapy session w/ med management	**90839**	$ 295.00	90 minutes
Parent/family consultation without client present * Pre approval needed*	**90846**	$ 302.00	30 minutes
Urgent therapy	**90839** **90840**	$ 382.80 $ 191.40	60 minutes per every additional 30 minutes

Medication refill requests < 3 business days	$ 150.00
Medication injections	$ 25.71
Forms and letters outside of appointment	$ 235.00/Hour, billed in increments of 15 min. ($57.75)
Letter to attorneys billed at separate rate	$ 450.00/Hour
Requested phone calls for established clients outside of medication inquiries. Including calls to or from agencies.	$60.00 / 15 minutes
Clerical fee for searching/handling records, per WAC	$ 25.00
Pages 1-30 (copying fee), per WAC	$ 1.12/ per page
Pages 31+ (copying fee), per WAC	$ 0.84/ per page
Editing of confidential information, per WAC	$ 160.00
Returned check fee, plus original amount due	$ 35.00
No show or late cancel (less than 48 business hour notice) fee for follow-up clinic visits.	$ 110.00

INSURANCE VERIFICATIONS: The biller will contact the client's insurance company to determine specific benefits. We will inquire about deductibles, co-pays, co-insurance, services covered and whether or not a referral authorization is required. Prior to the initial appointment, the client will receive a call from the biller regarding these benefits.

CHANGES TO INSURANCE: Should there be any changes to the client's insurance coverage, whether it be terminated, switched or if a new insurance has been added, we need to know of these changes as soon as possible to ensure all claims are paid out effectively and accurately. If we bill the client's insurance and the claim is later denied because of non-coverage, the financially responsible person on the account of the client will be held responsible for payment of services.

LABORATORY REQUESTS: Coverage for any lab work requested by the provider will not be verified by our office. It is the client's responsibility to verify insurance coverage regarding lab work through the facility in which they are being done. We are not responsible for any charges to the client regarding lab work.

GROUP HEALTH CLIENTS: Must call the Behavioral Health Clinic for a referral authorization before their initial appointment. You can find the number online or on the back of your insurance card.

PAYMENT ARRANGEMENTS: Special payment arrangements need to be discussed and approved by Dr. Hamlin prior to an appointment. These will be communicated to the biller. Any and all accounts that become 90 days delinquent are subject to collections.

PRIVATE BILLINGS: Clients without insurance may be offered a reduced rate, subject to the approval of Dr. Hamlin.

FORMS OF PAYMENT: In addition to cash or check, we kindly accept Visa, MasterCard, and Discovery for payment of services. There will be a $25.00 fee for returned checks due to insufficient funds.

PRIVATE BILLINGS FOR CLIENTS WITH INSURANCE: Please let us know if you have insurance, but wish to pay for your services out of pocket. We require all insurance information be on file. We will not bill the insurance unless specified by the client or the legal guardian of the client.

DUAL COVERAGE: To ensure that all insurance claims are processed accurately and in a timely manner, we ask that any and ALL insurances the client is insured under be given to the front desk. Withholding this information may cause the insurance to deny, postpone a payment or pay the claim(s) only to issue a refund request to the provider. If this happens, the client will then be responsible for said refund or payment for services until the claim(s) can be reprocessed and paid out correctly.

MINORS (18 OR YOUNGER): All clients under the age of 18 ***must*** have a parent or guardian sign this financial agreement as the financially responsible person on the account. Once the client turns 18, we ask that you let us know so we can update the policies on file. It is not the responsibility of my office to keep track of this information.

CANCELLATION POLICY: If you are unable to keep your scheduled appointment, please notify the office within 48 business hours, EXCLUDING WEEKENDS & HOLIDAYS, of the appointment. Any appointments that are not kept or that have been canceled with less than the required 48 business hours of notice are subject to a fee. A bill will be sent to the person who is financially responsible for the client's account.

____ I certify that I am eligible for benefits under my prepaid health plan. In the event that I am later found to be ineligible or in consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees that are then in effect.

____ I understand that the Information we receive is not a guarantee of the client's actual benefits and is subject to final processing by the client's insurance company. The client is responsible for all fees not covered by the insurance.

I have read and understand the above information and have been provided a copy at my request:

Client signature: (if 18 or older) **Date:**

_____ _____

Parent or guardian signature (if applicable) **Date:**

_____ _____

Print name: **Relationship to client:**