# Baxter Behavioral Health, LLC

1130 Ten Rod Road, D101 North Kingstown, RI 02852
P: (401) 267-4485 F: (401) 267-4534

## Office Policies for Baxter Behavioral Health, LLC

Patient Name: _____ D.O.B.: _____

This statement is to familiarize you with our new office policies, effective July 1, 2022.

Your provider, Baxter Behavioral Health, LLC, is committed to providing caring and professional mental health care. Clients are expected to be active participants in their care. This includes following treatment plans and making scheduled appointments. If medications are prescribed, it is the patient's right to receive information about the medication including potential adverse effects. All minors must be accompanied by a legal parent or guardian for all appointments. Unaccompanied minors will be denied non-emergency services. Additionally, as part of the delivery of mental health services, there is an established financial policy, which provides payment policies and options to all consumers.

**Insurance**: Your insurance policy, if any, is a contract between you and the insurance company. Your provider is not part of the contract with you and your insurance company. As a service to you, your provider will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and are not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the Person Responsible for Payment of Account is responsible for payment of these services. Your signature, on each line with an italicized X signifies that you have read, understand, and agree to abide by each of these policies.

**Fees:**
Initial Evaluation: $300.00
15-minute prescription review: $85.00
20-30 minute follow-up appointments for psychotherapy and medication management: $175.00
45-50 minute follow-up appointments for psychotherapy and medication management: $250.00
Returned Check Fee: $25.00
Nonpayment past 60 days: $10.00 (+$10 for each additional 30 days past)
Additional Services: $25.00 per 10 minutes

-This includes phone calls, letters, and emails with you, schools, hospitals, primary care practitioners and therapists. Please note that insurance does not pay for these services.
-All returned pager/cell calls will be charged for a minimum of 10 minutes if not related to an adverse reaction/side effect etc.

**You are responsible** to check with your insurance company regarding your coverage and to track your coverage. You are responsible for **all charges** not covered by your insurance company. All **payments** and **copayments** are **due at the time of service**. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, (i.e., if there were previous visits to other mental health providers) this amount will be collected by your provider until the deductible payment is verified by the insurance company or third-party provider. All insurance benefits will be assigned to your provider (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

**Payment:** *Please make checks payable to Baxter Behavioral Health, LLC.* You may also pay with any major credit card. If payment is not received, services may be discontinued. If you do not pay as agreed, your account may be turned over to an attorney or a collection agency, and you will be held responsible for any legal or collection costs incurred. **Insurance deductibles and copayments are due at the time of service.-**We**

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**will no longer bill you for these payments, they are expected at the time of service, or you will need to reschedule and pay a late-cancel/rescheduling fee of 100 dollars.**

I hereby authorize Baxter Behavioral Health, LLC to:

1. Furnish my insurance company with any/all information requested concerning my/my child's present claim(s), including records and psychotherapy notes, if requested.
   X_____
2. Bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care. I acknowledge that I am responsible for all charges not covered by my insurance. X_____

**Cancellations**: Please call to cancel with **at least 24 hours notice**; this includes weekends if your appointment is on a Monday. If you fail to cancel your appointment with 24 hours notice, you will be charged **$100.00**. Insurance companies will not pay for missed appointments. If you miss your appointment due to traffic or other concerns, the same rule applies. *It will be the discretion of the provider if the initial late-cancel fee can be waived, however under no circumstances will a missed appointment fee be waived.* **If you are more than 10 min. late and do not notify staff, you will be responsible for a $100.00 rescheduling fee. All balances must be paid ahead of rescheduling your next appt. or getting refills, unless you work out a payment agreement with your provider/staff.**

**Emergencies**: For after hours emergencies please call 911 or go to the nearest emergency room.

**Urgent Calls**: You may leave a message on your provider's confidential voicemail, 401-267-4485, after hours and on weekends. Please **do not send text messages!** Urgent needs include new suicidal thoughts, concerning side effects of medications, and worsening mental illness. Appointment changes and prescription refills are not considered urgent needs, and calls regarding these issues will not be returned.

**Prescription Refills**: Refills of medication are usually written at the time of the appointment. **Refills are not an emergency** and will be handled between 9 A.M. and 5 P.M. on Wednesdays and Fridays. It is the client's responsibility to track medications and when refills are required. If you are calling for a controlled substance, such as ADHD medication, (Adderall, Vyvanse, Focalin, Methylphenidate, etc.) it may take up to three business days to refill; this is not an emergency!

**Grievance Procedure**: I encourage you to discuss any complaints with me (Ryan Baxter) directly to resolve the problem/issue. You may also contact your insurance company.

**HIPAA Notice of Policies and Practices**: I am required by Federal Law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the HIPAA Notice of Policies and Practices should you wish to have a complete copy for your records.

**Signature:** Your signature below indicates that you have read this agreement and agree to all of its terms. You consent to receive prescription medications, possibly including neuroleptic or scheduled medications. You understand that if the terms of this agreement are violated, your therapy, or your child's therapy (if a minor), may be damaged and may require termination. Your signature also serves as an acknowledgement that you have received a copy of this document if you have requested it.

Patient's Name_____ D.O.B. _____

Signature of Responsible Party _____ Date_____