NORMUND J. AKOTS, PhD
10200 SW Eastridge Street, Suite 101
Portland, Oregon 97225
Telephone: (503) 292-9183
Fax: (503) 292-9280

Welcome to our practice! Your first appointment with Dr. Akots is scheduled for _____.
Please arrive 10 minutes early.

We are located in the Eastridge office building next to Cedar Hills Hospital. It is a two-story dark tan building with wraparound windows on all sides. It sits directly above the on-ramp to Hwy. 217 southbound close to the Cedar Hills Shopping Center and the DMV office.

See directions on reverse side.

Enclosed is paperwork for new patients. **Please complete and sign all forms and bring them to your first appointment.** Please bring your insurance card and driver's license for copying.

If you are using insurance, we will need to **call your insurance company** to verify your benefits for outpatient mental health before your first appointment**. We must get prior authorization if your insurance requires it.** Recorded below is the information that applies to your insurance:

Name of company that manages your mental health benefits_____

Number of sessions authorized_____

Authorization number_____
Please note, if we are unable to obtain an authorization number when required, your insurance may deny payment. This is not required by all insurance plans.

Copayment or coinsurance amount_____

Annual deductible_____

Deductible remaining for this year_____

Please bring payment for your copayment/coinsurance and deductible at the first visit.

If we are unable to verify your benefits in advance, you will need to pay $250 for the first appointment. Checks are payable to NORMUND J. AKOTS, PhD. Visa and Mastercard accepted.

NEW PATIENT INFORMATION - *Please print clearly in dark ink*

_____ _____ _____
Patient Name (First, Middle Initial, Last) DOB (month/day/year) Age

_____
Patient Address (Street, City, State, Zip Code)

Home Phone _____Work Phone _____Cell Phone_____
Email_____

May we call? Y N May we leave a message? Y N Social Security No. _____

Marital Status: Single Married Other Sex: Male Female

Employment: Employed Full-time Student Part-time Student Unemployed

Employer or School Name_____

Is your treatment related to employment? N or Y To an accident? N or Y (Date_____)

Primary Care Physician/Name & Phone_____ Referred by_____

If patient is a minor child:

Mother's name _____ Telephone _____

Father's Name_____ Telephone _____

Name of adult who is financially responsible for child's account_____

Primary Insurance Information

_____ _____
Subscriber's Name (First, Middle Initial, Last) DOB (mm/dd/yy)

_____
Subscriber's Address (Street No. , City, State, Zip Code)

Telephone (_____)_____ Social Security No. _____

Sex: M F Patient relationship to subscriber: Self Spouse Child Other

Subscriber's Employer _____

Insurance Co. Name_____ Member ID No._____

Group No. _____ Insurance Plan Name _____

Insurance Claims Address_____

_____ Insurance Telephone Number _____

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Secondary Insurance Information

_____ _____

Subscriber's Name (First, Middle Initial, Last DOB (mm/dd/yy)

_____

Subscriber's Address (Street No. , City, State, Zip Code)

Telephone (_____)_____ Social Security No. _____

Sex: M F Patient relationship to subscriber: Self Spouse Child Other

Subscriber's Employer _____

Insurance Co. Name_____ Member ID No._____

Group No. _____ Insurance Plan Name _____

Insurance Claims Address_____

_____ Insurance Telephone Number _____

Please have insurance card(s) available for photocopying.

For office use only;

Authorization #_____

Copayment: $10 $15 $20 $25 10% 20% Other_____

Deductible_____

DSM-IV Code: _____

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CONSENT TO SERVICES AGREEMENT

1. Psychotherapy is intended to benefit you, but there is no guarantee that your condition will improve or that you will be cured. You may stop treatment at any time. There are alternative therapies available to you from other providers, such as medical treatment, psychoanalysis, and meditation. During psychotherapy you may experience uncomfortable feelings about specific topics or events. This is a normal reaction and you should discuss these feelings with your psychologist.
2. Your participation in treatment and all information about you is confidential. You must provide written authorization to release such information except in cases of: (a) suspected abuse or neglect of children (b) situations where you may be in imminent danger of harming yourself or another person (c) when a court subpoenas your psychologist to testify or release records. In the event of serious illness or death of your psychologist, another psychologist will be appointed to manage your records and assist you in continuing your treatment.
3. By signing below you give consent for Dr. Normund J. Akots to disclose your health information as necessary to consult and coordinate with your other health care providers, and to supply diagnosis and treatment information to your insurance company for authorization and payment purposes.
4. In the event of couples' therapy, both parties must sign an authorization before records can be released.
5. Support by parents is a necessary condition for successful psychotherapy with a minor child. We will advise parents of the diagnosis and treatment plan and involve them in treatment as appropriate. However, we will respect the privacy of minors, especially adolescents aged 13-17, and will not disclose the content of individual sessions to parents. We will use our best professional judgment about what information is shared with parents, remaining mindful of the responsibility of parents to protect children from potentially harmful situations and behaviors.
6. We are required by Federal law (Health Insurance Portability and Accountability Act, known as HIPPA) 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 or your child may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPPA Notice of Policies and Practices* should you wish to have a complete copy for your records.
7. We subscribe to the Revised Ethical principles of the American Psychological Association, which can be made available for your inspection. If you should ever have a grievance that is not resolved with your psychologist directly, you may contact the Board of Psychologist Examiners

Your signature below indicates that you have read this agreement and agree to all its terms. Your signature also serves as an acknowledgement that you have received the HIPPA Notice of Policies and Practices described above.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Please print your name Relationship to patient

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OFFICE POLICIES AND FEE AGREEMENT

APPOINTMENTS: Appointments are 50 minutes long. Your appointment is held exclusively for you. Please arrive on time, as your appointment will not be extended if you arrive late. If you are unable to keep an appointment, you are asked to provide at least 24 hours' notice or **you will be charged a missed appointment fee of $100.** Please note that your insurance will not cover charges for missed appointments; you will have to pay the amount yourself.

EMERGENCIES: In case of emergency, you may reach me by leaving a voicemail message. Your call will be returned as soon as possible. My voicemail indicates a cell phone number for emergency contact when I am out of the office. If you are unable to reach my office or cannot wait for a return call, please call your physician or go to the nearest hospital.

FEES: The charge for the initial visit is $250 and $180 for subsequent 50-minute sessions. Shorter or longer sessions will be pro-rated at this same rate. You will also be charged this rate for additional services provided at your request or for your benefit (at the request of your insurance company or attorney, for example) such as report writing, consultation with other professionals, or hospital visits. Any legal or court work will be charged at $250, which includes preparation, travel, wait and testimony time. Copies of records are $25 for the first 10 pages.

INSURANCE: It is your responsibility to obtain authorization from your insurance company if it is required and you choose to use insurance. If you do not use insurance, you will be asked to sign a form stating so. You are advised to **review your insurance benefits for outpatient mental health**, including deductibles, copayments and provider networks. By signing below you obligate yourself to pay for all services, even if denied or not covered by insurance, regardless of the reason for non-payment.
As a service to you, we submit insurance claims for you. You are responsible for providing accurate and current insurance information, and for contacting your insurance company if claims are not paid. By signing below you authorize Dr. Normund J. Akots to make such inquiries as it determines necessary to confirm your insurance coverage, and to release any medical or mental health information necessary to process claims for services. You also authorize all payors to release benefit information to Dr. Normund J. Akots, and to make direct payment to Dr. Normund J. Akots of any insurance benefits otherwise payable to you.

BILLING: We bill monthly. Our billing cycle ends on the last day of the month. Payment of all fees, copayments and deductibles is expected at the time or service, or no later than the end of the month. A fee of **$25** will be charged for a returned check, and a **$25** *monthly* fee will be charged for delinquent accounts.

PLEASE NOTE: Overdue accounts will be turned over to an attorney or collection agency, and you will be obligated to pay reasonable associated costs.
Your signature below indicates that you have read this agreement and agree to all its terms.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Please print your name Relationship to patient