Natalie Kollross, Psy. D. Licensed Clinical Psychologist, LLC

Psychological Services of Pendleton, LLC
135 SE First Street
Pendleton, Oregon 97801
Ph: (541) 278-2222 / FAX: (541) 276-8405

OFFICE POLICIES

Natalie Kollross, PsyD is a clinical psychologist licensed by the Oregon Board of Psychologist Examiners. She earned her doctoral degree from Pacific University and completed a residency at OHSU and at Psychological Services of Pendleton. She is a member of the Oregon Psychological Association.

CONFIDENTIALITY: Information that you share in treatment is held in the strictest confidence possible under law. Dr. Kollross will not release information you have disclosed to her in the course of treatment or evaluation, with the following exceptions:

1. Information that you pose a "clear and imminent danger" to yourself or others.
2. Information that would assist others treating you for a medical emergency.
3. Information about treatment of minor children may in some cases be disclosed to their parents and step parents.
4. If you have been referred for a psychological evaluation, Dr. Kollross will ask that you sign an authorization releasing the results to the referring agency.
5. In some cases Dr. Kollross may be compelled by law to disclose information to the courts.
6. Information necessary for your insurance company to process your claim.

In the course of therapy Dr. Kollross may request information about you from your referring physician, other professionals or wish to communicate with these persons about your treatments. In such cases, you will be asked to sign an authorization granting permission for such communication. Please ask Dr. Kollross directly if you have questions about particular issues of confidentiality.

TREATMENT OF MINORS Dr. Kollross treats children of divorced or separated parents under the following conditions (unless otherwise ordered by the court): 1) The legal custodial parent must sign the consent to treat form prior to the initiation of treatment, 2) Dr. Kollross will consult with the non-custodial parent and step parents as needed 3) Non-custodial parents and step parents may bring the child to appointments and provide and receive updates of the child's behavior. 4) Appointments made by the legal custodian for a child during the child's visitation times with non-custodial parent should be arranged with the non-custodial parent's informed consent.

OFFICE HOURS at Psychological Services of Pendleton, LLC are from 8 AM to 6 PM Monday through Friday. For schedule information please call the office.

APPOINTMENTS: Sessions are made by appointment only. Dr. Kollross reserves the right to charge for no show appointments or those canceled less than 24 hours in advance (see "Late Cancelations" below). Occasionally Dr. Kollross may be late or have to cancel an appointment due to emergencies. Please keep our office staff informed as to how you may be reached in case it is necessary to change your appointment.

TELEPHONE CALLS may be made to Dr. Kollross during office hours, but therapy sessions will only be interrupted in case of emergency. All other calls will be returned at Dr. Kollross's earliest convenience. You are welcome to leave a brief and confidential phone message for Dr. Kollross after regular office hours. You will be responsible for any extended clinical related telephone conversations that are not billable through insurance. Charges for such phone calls will be prorated based on Dr. Kollross's current rate.

PSYCHIATRIC EMERGENCIES should be reported to our office immediately. If our office cannot be reached, please go to the nearest hospital emergency room. In certain cases, Dr. Kollross may offer you another emergency contact number.

MEDICATIONS: Dr. Kollross does not prescribe medications. If you are already taking psychotropic medications, Dr. Kollross will usually consult with your physician about your response to the medication and its effect on treatment. If Dr. Kollross determines that such medication may be helpful to you, she will refer you to a prescribing provider.

FEES Fees are based upon a 50-minute hour. Longer or shorter sessions will be charged on a prorated basis. Telephone calls, report preparation, copying, and sending records are additional services that will be charged separately. If you are unable to pay the current rate, a sliding scale is available for use in negotiating your fee agreement with Dr. Kollross. ALL RETURNED CHECKS ARE SUBJECT TO A FEE OF $25.00

BILLING AND INSURANCE POLICY: Our receptionist will request information from you about your insurance coverage when you first call for an appointment. Many health insurance carriers and their managed care companies now require preauthorization for your first visit. Our office will attempt to obtain this preauthorization with your help before the first visit with Dr. Kollross. Also, most insurance plans do not cover 100% of treatment costs. Under a traditional fee–for-service plan you will be responsible for any deductible amount (e.g., the first $200 per calendar year) and the percentage of each visit not covered by your plan (e.g., 20%). Under other insurance plans you are responsible for a copayment (e.g., $25 per session). The exact amount of your payment depends upon your insurance plan. Our staff will assist you in determining what your estimated financial obligation is. Dr. Kollross asks that you bring your portion of payment to each session.

If you do not have insurance coverage or are unable to pay your portion of the cost at each appointment, you may negotiate an alternative fee arrangement directly with Dr. Kollross.

You will receive a monthly statement from Dr. Kollross informing you of charges accrued for the month, and a cumulative balance on your account. In cases where an acceptable payment plan is not being followed, Dr. Kollross may turn the account over to a collection agency. If you have questions about your account, please contact our staff at Psychological Services of Pendleton, LLC.

LEGAL FEES Psychological Assessment, Testimony, Reports, Declarations, Letters and General Consultation (this includes preparation time, office visits, travel, reports, letters, and waiting time) will be charged at time and a half her usual fee per hour. If Dr. Kollross is required to block out her schedule, thus preventing her from seeing other patients, in order to attend court, she will bill for this time even in the case of trial cancellations.

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LATE CANCELATIONS: Dr. Kollross reserves the right to charge you a fee for missed or late canceled appointments without at **least 24 hours notice** prior to the appointment. You will be responsible for paying the fee for late or missed appointments. The fee will be added to your billing statement and will need to be paid before your next scheduled session.

Fees for missed or late cancel:

First	Grace
Second	Full Fee to be paid by the patient. A decision will be made by Dr. Kollross as to whether she will discontinue patient's treatment or refer to another provider.

TREATMENT PROGRESS will be monitored and documented in writing by Dr. Kollross. Although her services are dedicated to your improvement, Dr. Kollross cannot guarantee to "cure" your condition or situation. Much of your progress will depend on your efforts. Treatment is not limited to time you spend in the office, and may include "homework assignments" to work on between sessions. There may also be times when you wish a second opinion about your treatment from another professional, or when Dr. Kollross wishes a consultation with another professional about your case. Such outside consultations should be discussed with Dr. Kollross first. In the event that you wish to terminate treatment and seek services elsewhere, Dr. Kollross can provide you names of other professionals.

GRIEVANCES about treatment or office procedures should be brought to the attention of Dr. Kollross immediately. Unresolved grievances may be taken to the Oregon Board of Psychologist Examiners, (503) 378-4154.

CONSENT TO TREAT

Please ask any questions you may have before signing this agreement.

I have read the above Office Policy and agree to treatment/evaluation under the conditions described above. I acknowledge that I am financially responsible for all charges.

Patient Signature_____ Date: _____

Representative Signature: _____ Date: _____

Description of Representative: _____