

Interlake Psychiatric Associates, PLLC
2025 112th Avenue NE, Suite 200, Bellevue, WA 98004
(425) 462-9511 Fax (425) 462-8894

Office Policy

(Please initial after reading each paragraph)

OFFICE HOURS & APPOINTMENTS

Our main office is open from 9am to 5pm, Monday through Thursday. However, each practitioner has varied hours, and we will try, whenever possible, to fit appointments to your schedule. **A 24 hour cancellation policy is in effect.** Appointments cancelled without the required notice will be billed to the patient/parent. Missed appointments are not covered by your insurance. Please call as soon as possible to cancel your appointment so we may give that time to someone else. Initials_____

FINANCIAL RESPONSIBILITY

When completing our Patient Information form, the person listed as "Responsible Party #1" will be legally financially responsible for the account. This person is required to sign at the bottom of our form accepting financial responsibility. Unfortunately, we will not be able to divide financial responsibility between parties. Initials_____

PAYMENT

It is our policy to collect payment in full at the time of your appointment. **We gladly accept cash, check, VISA and MasterCard.** We do offer an Easy Pay Credit Card program. Contact the office for details. Initials_____

- **Statement Fee** – There will be a \$1 statement fee for unpaid accounts requiring a mailed billing statement. Initials_____
- **NSF Fee** – There will be a \$20 fee for all returned checks. Initials_____
- **Unpaid Accounts** – Accounts left unpaid may be given to an outside collection agency. Initials_____

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INSURANCE

Our doctors no longer participate with any insurance companies. Please contact your insurance company to verify your mental health benefits. Also, it is your responsibility to seek payment from your insurance. After you have paid for your appointment, we will provide you with a billing form that contains the information your insurance company requires from us to process your claim. You will be reimbursed directly from your insurance company. Initials_____

PHONE CALLS

As a courtesy to our patients, there is no charge for brief, routine phone calls and medication refills. However, calls requiring more than 5 minutes will be charged at the quarter-hour rate. Please note that phone calls are not covered by insurance and will be charged to the patient or responsible parent, unless other arrangements have been made with our clinician. If more time is required, please arrange an appointment (which may be covered by some plans).
Initials_____

PATIENT FORMS

A fee will be charged for any form requiring completion by your physician. The fee will be determined by your physician according to the intensity of the form.
Initials_____

ACKNOWLEDGMENT

Office fees, no-show fees, billing policies, NSF fees, Notice of Privacy Practice are all subject to change at the discretion of the PROVIDER. By signing this agreement, it is understood that you, or as the guardian of a minor, understand and agree to abide by our office policy and will accept the conditions thereof.
Initials_____

Patient Name

Personal Representative (parent)

Date