Bridger Psychiatric Services

Thank you for choosing Bridger Psychiatric Services (BPS). It is our mission to provide the most comprehensive and effective care possible. A responsible partnership between the physician, staff and patient will ensure you receive the most accurate and efficient treatment possible.

The following is a patient contract meant to ensure you are appropriately acquainted with our office policies and practices. Review this contract carefully and discuss any questions you may have with staff.

Confidentiality/Privacy Practices:
BPS complies with HIPAA regulations regarding the disclosure of health care information. We are legally required to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this contract so long as it remains in effect. We reserve the right to change the terms of this contract, as necessary. You may receive a copy of any revised contracts in the office or by mail.

All records are strictly confidential and none of your records will be released to a third party without a written release of information. Exceptions to the rule of confidentiality include situations in which you may be deemed a serious threat to yourself or others, situations where there is suspicion of neglect or abuse of children, elder adults, or other vulnerable adults. If a serious threat of harm is present, your information will be released to the appropriate parties to protect yourself or others. Care details may also be shared as part of continuity of care among current providers. Patient records are maintained for seven years by BPS, after which time they are destroyed.

We are permitted by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- Any purpose required by law.
- Public Health activities such as required reporting of disease, injury, births, deaths, immunization information and for required public health investigations.
- If we suspect abuse or neglect of a child, elder adult, or other vulnerable adult.
- To the Food and Drug Administration if necessary to report adverse events, products, defects, or to participate in product recalls.
- If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- If required to do so by a court or administrative ordered subpoena or discovery request; in most cases, you will have notice of such release.
- To law enforcement officials as required by law to report wounds, injuries, and crimes.
- If you are a member of the military as required by armed forces services, we may also release your personal health information if necessary for national security or intelligence activities.

Access to Your Personal Health Information:
You have the right to your personal health information. All requests for access must be completed in writing and signed by you or your representative. We will charge a fee if you request this information. You may obtain a record release form from our office.

You have the right to request that your personal health information to be amended or corrected. We are not obligated to make all requested amendments; however, we will give each request careful consideration. All amendment requests must be in writing and must state the reasons for the request.

Insurance/Billing:
It is your responsibility to contact your insurance company and verify your mental health benefits. We must have a copy of your current insurance card to process your claims correctly. You must keep BPS informed about changes in insurance. If the correct insurance information has not been provided to BPS, you are financially liable for all expenses, and it is your responsibility to submit any claims to the proper insurance company should you wish to do so.

You are authorizing BPS to contact your insurance company in reference to claims and to release documentation that is requested to process claims on your behalf.

We are in-network with **Medicare Part B, Montana Medicaid, and Mountain Health Co-Op.** BPS is not responsible for submitting to an out-of-network insurance company and has the right to refuse to do so. If we are not in network with your insurance, be prepared to pay for your office visits in full at the time of service.

If your insurance company rejects a claim for any reason, you are responsible for payment in full.

Any disputes regarding payment by your insurance are solely the responsibility of the patient and are to be resolved between the patient and insurance company.

I further agree and understand that claims will only be submitted that accurately reflect diagnosis(es) that are documented within my medical record, and that asking our clinic to otherwise is considered a fraudulent act.

I understand that there are some services and fees which are not covered by insurance, such services will be disclosed when relevant and detailed billing information will be provided.

If a third party is responsible for payment, you need to sign a release of information for that party to access detailed billing information.

We accept cash, checks, money orders and debit/credit cards. If we receive a returned check a fee will be added to your account for the returned check, and we may no longer accept your checks.

Failure to maintain a current balance may result in termination of services as well as collection activity. Our office will add a 30% fee for all accounts sent to a collection service, and you will be liable for this expense in addition to any fees accrued through the collections service.

If you have extenuating circumstances, please discuss payment options with the billing manager.

Appointments:
I agree to attend and be on time to all my scheduled appointments and understand that failing to do so will result in fees up to the full cost of the scheduled appointment. I understand that repeated offenses may result in being discharged from the practice. Cancellations must be made within 24 hours prior to the appointment time and understand that failure to do so will result in a late cancellation fee.

You are required to schedule and maintain regular follow-up visits per physician's instructions of the effectiveness of medication. Failing to make and keep follow-up appointments could result in lapses in medication and possible discharge from the clinic.

Telehealth:
The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. By agreeing to use these telehealth/telemedicine services, I understand, agree, and expressly consent to BPS obtaining, using, storing, and disseminating to necessary third parties, information about me, as necessary to provide the telehealth/telemedicine services and for billing purposes.

I understand that if I am utilizing insurance to cover telehealth/telemedicine services that the telehealth/telemedicine services may not be covered by my insurance plan, and it is my responsibility to look into my insurance coverage guidelines. I understand that I am financially liable for any outstanding balances not covered by my insurance.

I understand that when agreeing to telehealth/telemedicine services I am required to do so within a quiet and confidential space with secure and reliable service connection. If I am unable to do so, services may not be completed at that time and there may be associated fees. I understand that this is to protect my privacy and to create the optimal space for effective treatment.

Professional Fees:
Fees are listed on the Cost of Services Document. In addition to regular appointments, it is policy to charge the psychiatric hourly rate on a prorated basis for other professional services required. Other services include report

writing, letter writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service.

Our providers find that it is often unhelpful to participate in legal proceedings related to mental health and will decline to participate if asked to take part in any legal or court proceedings. If it becomes necessary for one of our providers to participate in a legal or court proceeding, there is a $350.00 per hour fee. You will be charged this rate for travel time, waiting time, preparation, and appearance time. Fees are due a week in advance of appearance, with any remaining fees to be billed upon completion of appearance.

Medication:
There is a 48-hour turnaround time for all prescription refills. Requests made over the weekend, or on holidays may take additional time. Refill requests made with less than 48-hour notice will not be filled immediately and may result in lapses in medication.

- I will take medications as prescribed by the physician.
- I will not misuse, change medication, or change doses of medications without first consulting with my physician.
- I will not sell, share, or give any of my medications to another person.
- I will inform my physician of all medications I am taking including those prescribed by other physicians as well as any over-the-counter medications or herbal remedies.
- I will inform my physician of any side effects or adverse reactions I may be having immediately.
- I understand that abruptly discontinuing my medications without the physician's knowledge may result in mild to severe withdrawal symptoms.
- I understand that combining alcohol, or other substances, with certain medications can promote depression and can cause sleep disturbances as well as other adverse reactions. Such substance use may also result in discontinuation of the prescribed medication.
- I agree to abstain from illegal substances and any other addictive substances that my doctor recommends be avoided, and to be open and honest about any use that occurs.
- I understand that I may be randomly evaluated for medication adherence or misuse at any time by oral swab or urinalysis.
- I agree that it is my responsibility to keep my medication in a safe and secure place. I further understand that if a medication is lost or stolen it may not be replaced, at the discretion of my provider.

I understand that failure to meet these guidelines may result in termination of services.

I understand that controlled substances cannot be sent across state lines by my provider and that I may only fill my medications within the state of Montana. I recognize that this means if I require any early or extended fills for travel it is my sole responsibility to work with my provider to obtain these fills with at least a week's notice prior to needing the fill. I also recognize that due to the nature of controlled substances early or extended fills may be denied by my provider, may not be covered by my insurance, and may also be denied being filled by my pharmacy.

Drug Screening:
I acknowledge that as part of my treatment I may be asked to complete an oral swab or urinalysis at random to monitor medication compliance as well as substance use. I understand that I may refuse to complete these screenings, however, doing so may impact my medication fills or my status as patient with BPS.

I understand that I am liable for any expenses incurred from such drug screening.

Conduct:
I agree to conduct myself in a courteous manner with physicians, staff members, and other patients in the office and on the phone. I understand that failure to do so may result in termination from the clinic.

I agree not to conduct any illegal or disruptive activities at BPS. I understand that any illegal or disruptive behaviors/activities observed, or suspected, by office staff or the employees of my pharmacy will be reported to my provider and could result in termination of services.

Continuity of Care
In order to provide comprehensive and effective care, BPS will maintain contact with other providers that are currently providing you care. This would extend to Primary Care, Counselor, or any other specialists you may be seeing that have information pertinent to your mental health.

Please include the names of anyone else who may be involved in your care (e.g. parent, spouse, etc). This information will allow our office to identify you as a patient to these select individuals for the purpose of scheduling, payment, and payment requests. An Authorized to Disclose Protected Health Information will be required to share more detailed information regarding your care.

Name	Phone Number	Relationship to Patient

Emergency Contact Information:

If there is a medical emergency that demands immediate attention, call 911 or go to the nearest emergency room.

For all other emergencies direct your phone calls to our office at (406) 586-5511.

If it is after normal business hours (Monday - Thursday 8:00am-5:00 pm and Friday 8:00 am-12:00pm) please call the **Help Center at (406) 586-3333** and have Dr. Olson paged.

I have read and fully understand all the information contained in the treatment contract. Failure to comply with the treatment contract may result in my being discharged from the clinic.

_____	_____	_____
Printed Patient Name	Patient Signature	Date
_____	_____	_____
Printed Patient Guardian Name (If Applicable)	Guardian Signature	Date