

Timeline Integrative Psychiatry
Margarita Holsten, MD

Office Policies

- 1. Failures to keep appointments hamper our efforts to be efficient and compromise our ability to help you.. Our office policy is therefore to charge half-appointment fee for "no-shows" or appointments cancelled with less than **48** hours' notice.

- 2. We request that you submit a current credit card on file before your first visit. If you have not submitted your payment information by 24 hours before the time of your first scheduled appointment, your session may be rescheduled, and you may be considered a "no-show" and billed according to our office policies and procedures.

- 3. You will receive an invoice following each visit, which will include the applicable billing codes for your visit, which you may submit to your insurance for any available out-of-network benefits. A billing code is a string of digits or letters or both that is assigned to each diagnosis or procedure. Your card on file will be charged for the full amount on the day of your appointment.

- 4. Please submit all required paperwork and consent forms at least 24 hours before your first scheduled visit. If you have not returned the required paperwork by the time of your scheduled appointment, your session may be rescheduled, and you may be considered a "no-show" and billed according to our office policies and procedures.

- 5. We believe in the importance of a truly whole-person approach to health care. In line with that philosophy, and because of the unique nature of telemedicine practice, we strongly recommend that all our patients have an ongoing relationship with a local primary care provider, and that you authorize us to collaborate with that provider in your care. You will need to provide a signed release for us to communicate with your primary care provider when you submit your initial patient paperwork.

- 6. In the course of your treatment we may refer you to another practitioner who provides a different type of care (ie: therapist, integrative medicine specialist, acupuncture, dietician) and it will be important that we can communicate and collaborate with these providers for the success of your treatment. A release consent form to sign will be provided for you in order to give us permission to communicate with another practitioner.

- 7. It is our intention to provide prompt, friendly email and telephone support to address questions or concerns you may have between visits at no charge. However, we do ask that you keep the volume of emails and calls within reasonable limits, in order to allow us to continue to reply in a timely fashion to all our patients.

Please note that if the volume of communication becomes excessive or if this privilege is abused in any way, Dr. Holsten reserves the right to bill you for her time to address your messages at her normal hourly rate. She will discuss any concerning communication patterns with you directly before implementing this email and phone policy.

- 8. Use of email in the medical setting can be challenging due to privacy issues. Email may be used to communicate issues such as scheduling and sending out resources or referrals. Communicating regarding clinical care, especially in urgent situations, is not appropriate for email. There are no established timeframes for responses to email guaranteed. Any Protected Health Information (PHI) shared in an email cannot be considered secure or guaranteed confidential though encrypted email is typically used by this office. The email option in your Power2Patient Portal is PHI secure and can be used to exchange clinical information.

Please, see Email Consent and Guidelines form for more details.

- 9. We are happy to complete paperwork or other letters for legal, insurance, and other reasons. We charge our normal hourly rates for such work, billed in 15 minute increments.

- 10. Dr Holsten reserves the right to terminate the professional relationship with any client at any time. Typically, this may occur if the relationship is not satisfactory due to failure to follow recommendations, failure to follow office policies, or to honour financial obligations. Specifics of these circumstances will be discussed as needed. As the client, you are under no obligation to continue treatment with Timeline Integrative Psychiatry and may decide to terminate the relationship at any time. If you wish to terminate, please alert the office in writing if possible.

I, _____, have read and understand these Office Policies and Procedures, and I agree to abide by them. I have been given adequate opportunity to ask all my questions, and to all of them I have received answers satisfactory to me in language I understand. As I sign this document, I am not under the influence of alcohol or of any other drug that might impair my understanding.

Date: _____

Patient Signature

Patient Name (Printed)

If the patient cannot sign this form owing to incapacity, an authorized personal representative such as a guardian or a health care power of attorney should sign this document on the individual's behalf.