**Richard Bingham, M.D.**
**Julie Bingham, Ph.D.**
www.whatsupdoc.us

**528 Cottage Street NE, Suite 1D**
**Salem, OR 97301**
**V: 503-584-9923; F:503-584-0303**

Dear Parent/Patient:

Enclosed is your new patient packet. Please complete the forms and return back to our office with the onetime $55.00 clinical fee as discussed. The background history can be turned in at a later time. Once we have both the initial registration paperwork and the clinical fee back, we will give you a call to schedule the first initial appointment. Appointments are generally 8-10 weeks out from the time we receive your information. If you need care before the set appointment, keep involved with your primary care or current therapist until you are able to attend your first appointment. Once we schedule your appointment, further questionnaires will be sent out at this time. Please complete and have these forms returned back at our office along with any relevant information, before your appointment.

If you have any further questions please feel free to contact our office at 503-584-9923.

Sincerely,
Richard Bingham, M.D.LLC
Julie Bingham, Ph.D. LLC

## PATIENT REGISTRATION FORM

Richard Bingham, MD and Julie Bingham, Ph.D. Date: _____

| | | | |
|---|---|---|---|
| Patient Name | | Gender M F | DOB |
| Street | | City | |
| State | Zip Code | Phone | |
| Mother Name | | Address | |
| Mother's Employer | Occupation | | Home #:<br>Work#: |
| Father's Name | | Address | |
| Father's Employer | Occupation | | Home#:<br>Work#: |
| Step parent's Name | | Address: | |
| Step parents Employer | Occupation | | Home#<br>Work# |
| If divorced describe custody status | | | |
| Identify Adults with whom the child lives Parents Other (please explain) | | | |
| In case of emergency, who do we notify (other than parents) Name: | | | |
| Relationship to Patient: | | Home # | Work# |
| Patients Marital Status: Married Single Divorced Spouses name: | | | |
| Referred by: | | Primary Care Physician | |

## INSURANCE / BILLING INFORMATION

| | | |
|---|---|---|
| Responsible Party | Relationship to Patient | |
| Address | Phone | |

| | | | |
|---|---|---|---|
| Primary Insurance | | ID# | Grp# |
| Insurance Address | | Phone | |
| Policer Holders Name | DOB: | Employer | |

| | | | |
|---|---|---|---|
| Secondary Insurance | | ID# | Grp# |
| Insurance Address | | Phone | |
| Policer Holders Name | DOB: | Employer | |

**Information, Billing, and Treatment Agreement**
**Julie Evans Bingham, Ph.D. -- Child, Adolescent, and General Psychologist**
**(503) 584-9924**

**Emergencies:** In the case of an urgent emotional or behavioral issue, I—or a covering colleague if I am out of the office—am available by phone. Please call my Voicemail first (503-584-9924) to determine any "out of office" instructions (e.g., which colleague is covering emergencies for me and how to reach him/her). Otherwise, my pager (**503/945-9696**) is available, 24 hours a day, 7 days a week. I usually respond within two hours, but please feel free to page again, in case an error was made in the page. Since I do not have a back-up system, it is possible my pager may malfunction without my awarenss, so it may be important to try other resources (e.g., Salem Psychiatric Crises Center is 503/585-4949 or the Salem Hospital ED number is 503/561-5373). If help is needed more urgently, use the usual community resources by calling 911, if appropriate, or go to your nearest hospital emergency department (ED).

**Billing:** Usually I will bill your insurance company directly for your convenience (I often have an agreement with the insurer to do so). **However, all deductibles and co-insurance payments are to be paid on the day the service is provided.** At this time, I only accept checks and cash, so please arrive prepared (i.e. I am unable to accept debit or credit cards). It is your responsibility to know your policy coverage, to confirm with us that pre-authorization or notification was done if required, and to know the limits of your coverage, including both dollar amounts and session limits. I may know this information as well and will endeavor to let you know the exact amount due at the time of service. However, periodically, these "best estimates" leave a balance or a credit on your account which we will address as soon as it is feasible. Balance statements are sent periodically, or upon request, and accounts are payable in full at the time of billing. If your account becomes "past due" I will assess a **finance charge** to the balance each month until it is paid in full.

**Fees:** Fees are subject to change without notice as per contracts and standard fee schedule increases. Also, your insurance does not cover certain services that I may pass on to you directly, as allowed in insurance contracts. These services will **always** be specified with you prior to incurring any charges. For instance, **all new assessments will be charged $55** for the initial clinical questionnaires, scoring and interpretation in order to provide for a more complete evaluation. Other services that may be billed to you directly (but will **always** be discussed before charges are incurre) include: review of outside records (Note: there will never be a charge for review of primary care medical records), review and interpretation of previous evaluations or questionnaires, non-emergency phone calls over 5-minutes, calls to schools, etc. (Note: there is no charge for conversations with the primary care physician or current psychiatrist). These services will be billed at $2 per minute for time over five minutes. I will work to keep all costs down while providing a high level of care, but please feel free to discuss any charges and the reasoning behind the need. Individuals who are paying "out of pocket" or without insurance coverage, can check my website for an updated fee schedule. Current fees for common services, (time) and billing codes, include: Psychiatric Assessment (45 minutes) 90801---$275; Individual Psychotherapy full session (45 minutes) 90806--$165; Individual Psychotherapy, half session (20 min.) 90804--$110; Family Psychotherapy (50 min.) 90847--$200; Neuropsychological Assessment, per hour, 96117--$200. Note: Forensic evaluations or court appearances are by special arrangement only, and fees will be negotiated at that time.

**Cancellation Policy and Billing:** When you make an appointment, my time is set aside to see you, your child or other family members. If you do not show up for the appointment or cancel the appointment late, then I am not able to use the time I had promised to you to see another child or family. **Please take this matter seriously.** If you fail to show up for an appointment or cancel without giving me at least **24 hours notice** there will be a charge of $70 for half sessions and $120 for full sessions. **Your insurance will not pay for these charges; these charges will be billed directly to you and are due in a week after the missed appointment date.** Exceptions for late cancellations will only be made in the case of illness or emergencies. I must be notified of the nature of the illness or emergency and only I (not office staff) can waive the charge if I determine it is appropriate.

I have read and understood the information above and agree to the stated policies.

_____ _____

Parent, Legal Guardian, Adult Patient Date
(Person Assuming Financial Responsibility)

**Julie Evans Bingham, Ph.D.**
**Clinical Psychologist**
www.whatsupdoc.us

528 Cottage St NE, Suite 1D
Salem, OR 97301
Ph: 503-584-9924; Fax: 503-584-0303

## CONFIDENTIALITY & LIMITS OF CONFIDENTIALITY POLICY

Confidentiality: Respecting the privacy of my client/patient's health and mental health information is of utmost importance to me as we work together. Your right to confidentiality of this information is guaranteed by state and federal laws as well. The policies listed below are consistent with these laws as well as the ethical standards of my profession. If release of your confidential information is requested by you or is suggested by me, it will be released only after you have signed a Release of Medical Information form. Certain kinds of situations and information may be released in the case of the exceptions noted below:

1. If there is clear and imminent danger to the patient/client or to others, then confidentiality may be waved in response to the "duty to warn" provision of the law. This may result in discussions with those in danger or discussion of the situation in order to arrange for emergency treatment;
2. Physical or sexual abuse of a child, developmentally disabled person, or dependent elder person, it must be reported to the appropriate authorities by anyone defined by law as a mandatory reporter;
3. If you confide that you may commit, or have committed, a crime or harmful acts;
4. If I am required by a court to give information;
5. Within marital or couples therapy, limits of confidentiality between partners will be handled on a case-by-case basis;
6. Parents of adolescents (14 and over in Oregon), may obtain records directly only with the written consent and signature of the child. **Information exchange with parents will be discussed and planned at the beginning of therapy**. These adolescents (as above) may obtain or refuse treatment on their own without parental knowledge. Parents of younger children may have access to mental health records. Until the patient/client reaches the age of 18 (or obtains "emancipated minor status"), parents MUST be contacted under certain situations.

If any of this is a concern for you please discuss this with me. Your signature below indicates that you have read and understand this information about confidentiality and have been provided with a written copy.

_____ _____
Patient Name Julie Evans Bingham, Ph.D. (witness)

_____ _____
Signature of Patient (age 14+) Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

# AGREEMENT TO CONDITIONS OF PSYCHOLOGICAL EVALUATION OR TREATMENT

**Julie Evans Bingham, Ph.D.** **Licensed Clinical Psychologist**

**Patient Name:**_____

**MEDICAL CONSENT:** I wish for my child/children or myself to have a psychological evaluation by Dr. Bingham. If appropriate and available I also wish for my child/children or myself to become a patient of Dr. Bingham. I authorize Dr. Bingham or any other psychologist authorized by her to provide such psychological or neuropsychological services, either regular or emergency, as may be determined to be in the best interest of my child/children or myself who are under her care. This authorization shall continue and be in full force and effect for one calendar year or until revoked in writing by me.

I have read the above and fully understand it, and have asked questions about anything not clear to me, and am satisfied with the answers I have received. I am the patient's parent, legal guardian, or the adult patient or I am authorized to consent on behalf of the patient.

_____ _____

Date Parent, Legal Guardian, Adult Patient

_____ _____

Date Adolescent Patient's Assent or Consent

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**AUTHORIZATION TO RELEASE INFORMATION TO INSURER:** I authorize Dr. Bingham to release from my psychological records any information required by my insurance carrier or any person, corporation, or agency responsible for managing the care or processing of my claims for medical and mental health benefits. I understand that if an insurance company or government agency is paying for my medical or mental health care, they may have access to sensitive information about my diagnosis and treatment. This authorization is valid for the life of the claim.

**ASSIGNMENT OF INSURANCE BENEFITS:** I authorize payment directly to Dr. Bingham of all insurance or health plan benefits otherwise payable to me, to the extent of the patient's bill.

**FINANCIAL AGREEMENT:** I agree to pay Dr. Bingham for services provided to me. **I understand I am financially responsible for charges not covered by my insurance or other agency, such as any deductible and coinsurance payments and that these fees may change without notice.** All accounts are payable in full at the time of service. If after 60 days the insurance payment is not received, the balance in full becomes my responsibility. If my account becomes past due, I may be required to pay interest on the unpaid balance. If this account is placed in the hands of an attorney or collection agency, I will pay reasonable attorney's fees and collection costs, whether or not a suit is filed.

I certify that I have read the above, including the financial agreement, and fully understand it. I am the patient's parent, legal guardian, or the adult patient or I am authorized to execute and accept the terms of this agreement on behalf of the patient. I assume individually all financial responsibility by noting my signature below.

_____ _____

Date Parent, Legal Guardian, Adult Patient,
Person Assuming Financial Responsibility

# Initial Clinical Questionnaire

*[In this questionnaire "child" refers to kids of all ages, birth to 21 years.]*

Child's Name: _____ Age: _____ Gender: [ ] M, [ ] F
Your Name & Relationship: _____ Today's Date: _____
Primary Care Physician (child's): _____
Therapist (list any from the past year): _____ [ ] current
How did you get my name? _____.
If a person gave you my name, are they: your child's [ ] primary care physician; [ ] therapist; your: [ ] therapist; [ ] friend; [ ] family member; [ ] religious leader; [ ] other: _____.

1. Are there concerns about suicide risk? [ ] no, [ ] yes: _____
_____.
2. Are there concerns about violence toward others (toward whom)? [ ] no, [ ] yes: _____
_____.

*If you have concerns about the risk of dangerous behavior in the near future, then you should consider whether it is necessary to see someone who could see you sooner (I am most likely to first see you between three weeks and three months from the time of our upcoming phone call). Your child's therapist or your primary care physician can help you make the decision about whether to wait for an appointment with me or not. Of course, hospital emergency departments or crisis centers are sources of emergency help, and should be used if necessary.*

3. Is this assessment needed primarily for a legal matter (e.g., related to a custody decision or a civil suit)? [ ] no, [ ] yes: _____.
*[Note: I do forensic evaluations only by special arrangement.]*
3. Does your child have a specific diagnosis (es) for this problem? [ ] no, [ ] yes: _____
_____.
4. Is there a question as to whether your child has a particular diagnosis? [ ] no, [ ] yes: _____.
5. Is he/she missing school or work due to this problem? [ ] no, [ ] yes: _____
_____.
6. Are there known or suspected psychotic symptoms (e.g. hallucinations, delusions, or very bizarre behavior)? [ ] no, [ ] yes: _____
_____.
7. Are there concerns about Substance Abuse? [ ] no, [ ] yes: _____
_____.
8. Are there serious current or chronic general health or medical problems? [ ] no, [ ] yes: ___
_____.
9. Is there a known or suspected developmental delay, intellectual disability ("mental retardation"), or Autism Spectrum Disorder? [ ] no, [ ] yes: _____
_____.
10. Are other agencies involved? [ ] no, [ ] yes: _____.
[ ] IEP at School; [ ] 504 at School; [ ] Juvenile Justice; [ ] County Developmental Disabilities; [ ] Child Protective Services/Child Welfare (DHS); [ ] Other: _____.
11. Is your child currently taking medication for an emotional or behavioral problem? [ ] no, [ ] yes (please list the daily dosage for each medication): _____
_____.
12. Has your child had prior intensive treatment? [ ] no, [ ] yes: _____.
[ ] Inpatient; [ ] Residential; [ ] Day Hospital: [ ] Day Treatment; [ ] Other: _____.
13. How is your access and comfort with basic use of the internet? [ ] limited; [ ] adequate and reasonably accessible; [ ] home or other easy access to high speed, comfortable with basics.