

## Paul P. Roberts, M.D., Office Policies

### Notice of Privacy Practices

No one except me has access to the personal information that I receive from you in my practice. I will hold all such information, including the fact that you are my patient, strictly confidential, with these potential exceptions:

- To coordinate care with your other providers.
- When you give explicit consent to release it.
- When disclosure is necessary to protect you or another person or persons from danger.
- When I respond to subpoenas, court orders, or legal process.
- When necessary to obtain payment that is due.

#### **You have a right:**

- To see your medical record, and to prepare a statement of disagreement which will become a part of your record.
- To request a list of disclosures of medical information that have been made.
- To cancel prior authorizations for release of your medical records.
- To be informed if your personal data is compromised.
- To specify that certain services not be disclosed to your health plan or insurer, provided you pay cash for those services.

If you have questions or concerns about privacy practices, record keeping, or any of these policies, please contact me directly. You can complain about privacy violations to government agencies:

WA State Department of Health  
510 Fourth Ave. W, Suite 404  
Seattle, WA 98119

or the

U.S. Secretary of Health and Human Services  
Office for Civil Rights  
U.S. Department of HHS  
200 Independence Ave. SW, Room 509F  
Washington, D.C. 20201.

### Contacting me

Use my office phone, 206-382-1555. Leave routine messages, questions, or requests on the voice mail there. The voicemail prompt will give current instructions for urgent or exceptional situations. I do not interrupt patient visits for

phone calls. If there is a life-threatening emergency, you should call 911 or go directly to a hospital ER, then call me.

**Telephone crisis management and clinical decision-making** will be charged at \$5.00/min.

My email is [paulrobertsmd@protonmail.com](mailto:paulrobertsmd@protonmail.com). It is HIPAA compliant, but your outgoing email is unlikely to be HIPAA compliant; to send me an email means you waive that level of confidentiality. Please use email only for administrative issues such as scheduling, and telephone for clinical matters.

### Cancellations and No Shows

If you will be unable to keep an appointment, please cancel as early as possible. **You will be charged for missed appointments**, or cancellations with less than two full working days' notice (e.g., for a Monday noon appointment, by noon Thursday). Insurance companies will not pay missed appointment charges. This applies even in cases of illness, bad weather, etc. If you are unable to come to the office you can have your session by videoconference or phone.

For recurring appointments there is a limit of five weeks per year of appointment cancellations, prorated for partial years, in addition to the appointments I will cancel for my own schedule. See [https://www.paulrobertsmd.org/?page\\_id=118](https://www.paulrobertsmd.org/?page_id=118) for details.

### Prescriptions

Have your pharmacy contact me by fax for a refill authorization.

### No Surprises Act Notification

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1

business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit

[www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

My fee schedule is stated at [www.paulrobertsmd.org/?page\\_id=68](http://www.paulrobertsmd.org/?page_id=68).

Limitations you should be aware of in any Good Faith Estimate:

- Psychiatric diagnosis is almost never known in advance with precision, and is likely to change from any pre-visit estimate.
- Duration of treatment can never be known with accuracy in advance.
- I do not do medication management without psychotherapy, and I do not do psychotherapy at frequency less than one hour per week.

**Payment**

I do not take Medicaid, Medicare, Medigap, or Medicare supplements. If you have another insurance secondary to Medicare, be aware that it may not be applicable, even if I am a contracted provider with that insurance company. If you have Medicare, even if you have another insurance as well, you are required before seeing me to sign this form:

[https://www.paulrobertsmd.org/?page\\_id=122](https://www.paulrobertsmd.org/?page_id=122)

I will send you a statement monthly. Payment is due by one month after the statement date. Balances unpaid by one month after the due date will accrue interest charges at a rate of 9% per year, unless you have made another payment arrangement with me, or unless an insurance claim for those charges is pending with one of the companies with which I have contracted.

If your insurance is one of those, then I will submit a claim for current charges to them at the same time I bill you. You will receive a notice from them called “Explanation of Benefits” which

will indicate what part of the current charges it is your responsibility to pay. You should send me that amount, plus any previous balance shown on your bill.

If you have insurance for which I am not an in-network provider, you are responsible for paying me by the due date regardless of any claim activity or pending reimbursement between you and the insurance company.

**Acknowledgment:** I have received a copy of this notification of policies. I have received, or waive the right to receive, a No Surprises Act written estimate.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date