Dale B. Mortimer, M.D., P.C.
Physician
General and Adult Psychiatry
Child and Adolescent Psychiatry
Diplomate, American Board of Psychiatry and Neurology

Completion of this form in its **ENTIRETY** is required at the time of the visit.

PATIENT INFORMATION

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Cell phone number: _____
Work phone number: _____
Social security number: _____
Date of birth: _____
Age: _____
Male/Female (circle one)
Marital Status: _____
Occupation: _____
Name and address of employer: _____
_____

PATIENT'S SPOUSE INFORMATION

Last name: _____
First name: _____
Middle name: _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____
Social security number: _____
Date of birth: _____
Occupation _____
Name and address of employer _____
_____

PERSON ASSUMING FINANCIAL RESPONSIBILITY FOR THE PATIENT

(person signing this form)

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Previous address (if less than 3 years): _____
Social security number: _____
Date of birth: _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____

Occupation: _____
Employer's name: _____
Employer's address: _____
City: _____ State: _____ Zip code: _____
Employer's phone number: _____
Relationship to patient: _____

INSURANCE INFORMATION

Name and address of primary insurance company_____
_____
Insurance company phone number: _____
Policyholder's first and last name: _____
Policyholder's date of birth: _____
Policyholder's employer: _____
Policy number: _____
Group number: _____
Policyholder's relationship to patient: _____

LOCAL FRIEND OR RELATIVE OTHER THAN LISTED ABOVE

Name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Relationship to patient: _____

REFERRED BY

Patient's primary care physician: _____
Referred to me by: _____
Reason for referral: _____
Previous therapy? _____
If so with whom? _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.

I hereby authorize Dale B. Mortimer, M.D., P.C. to bill my insurance company and accept payment from that company on my behalf for all services. I hereby authorize Dale B. Mortimer, M.D., P.C. to provide my insurance company with any/all information requested concerning my present claims relating to my care. I acknowledge that I am responsible for all charges not covered by my insurance.

Responsible party's signature: _____ Date: _____

AUTHORIZATION TO PROVIDE REASONABLE AND PROPER MEDICATION CARE

Patient's signature: _____ Date: _____

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PATIENT INFORMATION

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Social security number: _____
Date of birth: _____
Age: _____
Male/Female (circle one)

PATIENT'S FATHERS INFORMATION

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Previous address (if less than 3 years): _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____
Social security number: _____
Date of birth: _____
Marital status: _____
Occupation: _____
Employer's name: _____
Employer's address: _____
City: _____ State: _____ Zip code: _____
Employer's phone number: _____

PATIENT'S MOTHERS INFORMATION

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Previous address (if less than 3 years): _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____
Social security number: _____

Date of birth: _____
Marital status: _____
Occupation: _____
Employer's name: _____
Employer's address: _____
City: _____State: _____ Zip code: _____
Employer's phone number: _____

PERSON ASSUMING FINANCIAL RESPONSIBILITY FOR THE PATIENT

(person signing this form)

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Previous address (if less than 3 years): _____
Social security number: _____
Date of birth: _____
Marital status: _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____
Occupation: _____
Employer's name: _____
Employer's address: _____
City: _____ State: _____ Zip code: _____
Employer's phone number: _____
Relationship to patient: _____

INSURANCE INFORMATION

Name and address of primary insurance company_____
_____
Insurance company phone number: _____
Policyholder's first and last name: _____
Policyholder's date of birth: _____
Policyholder's employer: _____
Policy number: _____
Group number: _____
Policyholder's relationship to patient: _____

LOCAL FRIEND OR RELATIVE OTHER THAN LISTED ABOVE

Name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Relationship to patient: _____

REFERRED BY

Patient's primary care physician: _____
Referred to me by: _____
Reason for referral: _____

Previous therapy? _____
If so with whom? _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.
I hereby authorize Dale B. Mortimer, M.D., P.C. to bill my child's insurance company and accept payment from that company on my child's behalf for all services. I hereby authorize Dale B. Mortimer, M.D., P.C. to provide my child's insurance company with any/all information requested concerning my child's present claims relating to his/her care. I acknowledge that I am responsible for all charges not covered by my child's insurance.

Responsible party's signature: _____ Date: _____

AUTHORIZATION TO PROVIDE REASONABLE AND PROPER MEDICATION CARE

Parent or legal guardian signature: _____ Date: _____

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TREATMENT CONTRACT WITH DALE MORTIMER, M.D., P.C.

As part of my written treatment contract with Dr. Mortimer, I understand that Dr. Mortimer will do his best to provide the patient indicated below with competent medical/ psychiatric treatment. In return, I promise to make treatment with Dr. Mortimer a very high priority. Among other things, this means:

1. The patient will keep all appointments with Dr. Mortimer and will arrive in his office on time (earlier is better);
2. The patient will follow–through with the agreed–on treatment plan;
3. The patient will abstain from all marijuana, alcohol, cocaine, hallucinogens and other non-prescribed substances of abuse;
4. The patient will establish and/ or maintain a professional relationship with a primary care physician;
5. The patient makes an inviolable commitment to no self–harm;
6. The patient will make a sincere effort to be as truthful, honest and candid with Dr. Mortimer as he or she can be;
7. The patient (or the parent/ guardian) will keep any medication that Dr. Mortimer prescribes for the patient in a safe location which is secure from theft and diversion;
8. The patient will take all medications prescribed by Dr. Mortimer as directed;
9. The patient agrees to honor and obey all laws; and
10. The patient (or the parent/guardian) will notify Dr. Mortimer right away if any of the above treatment contract conditions will not be met.

I understand that while Dr. Mortimer cannot make any guarantees regarding a successful treatment outcome. However, I also understand that he will do his best to provide the patient with competent medical/ psychiatric treatment.

I understand the above conditions of the treatment contract with Dr. Mortimer for the patient listed below, and I hereby promise to honor the treatment contract as outlined above.

Name of patient: _____

Signature of patient or parent/guardian: _____ Date: _____

Dr. Mortimer's signature: _____ Date: _____

10,000 NE 7th Ave., Suite 385 ▪ Vancouver, WA 98685 ▪ Phone: (360)882-9058 ▪ Fax: (360) 567-0861

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FEE SCHEDULE (effective date: 2/15/2021)

In January 2013, there were major changes made in the physicians' procedural terminology (CPT) codes to more accurately and fairly reflect the psychiatrists' time and cognitive work involved in evaluating and treating their patients. To wit: these most recent revisions in the CPT codes are an attempt to correct the systematic and unjust devaluing of psychiatrists' professional medical and psychotherapeutic services by far too many medical insurance carriers. Do keep this Fee Schedule as a reference for interpreting both my billing statements and your medical insurance carrier's Explanation of Benefits ("EOB"). The CPT is a listing of descriptive terms and codes used by physicians to report the medical and psychiatric services and procedures that physicians provide for the benefit of their patients. [E&M: "medical evaluation and management"] Below are the most common codes I use.

Physicians' Current Procedural Terminology (CPT) Codes		Fees
99205	Diagnostic evaluation, new patient (first hour of assessment)	$770
99213	Office visit, medical evaluation and management, 13–20 minutes	$450
99214	Office visit, medical evaluation and management, 21–32 minutes	$535
99215	Office visit, medical evaluation and management, 33 or more minutes	$690
96127	Use of standardized instrument properly interpreted & documented	$25
96146	Neuropsychological test administered with automated standardized instrument	$25

New "add–on" CPT codes		
+90785	[E&M] Plus "interactive complexity", (e.g., young patient; family members present; schools involved)	$80
+90833	[E&M] Plus psychotherapy as part of – not in addition to – the office visit, 16–37 minutes	$145
+90836	[E&M] Plus psychotherapy as part of – not in addition to – the office visit, 38–52 minutes	$230
+90838	[E&M] Plus psychotherapy as part of – not in addition to – the office visit, 52 or more minutes	$365
+99050	Professional medical services outside normal business hours in addition to basic service	$190
+99358	Review extensive records, before or after office visit without patient, first 60 minutes	$330

Professional Services Not Usually Covered By Insurance		
90889	Special report prepared by Dr. Mortimer for an agency or for another physician	$770/hr
99011	Broken appointment (*without* the required 2 working days' notice)	$770/hr
99080	Special report prepared by Dr. Mortimer at patient's or family's request	$770/hr
99441	Phone call from patient or family to Dr. Mortimer; 5–10 minutes of medical discussion; pull and review patient's medical record, document content of call and clinical decision–making rational	$70
99442	Phone call from patient or family, 11-20 minutes of medical discussion; pull and review chart	$145
99443	Phone call from patient or family, 21-30 minutes of medical discussion; pull and review chart	$220

"Unofficial" Codes Used By Dr. Mortimer's Office		
00000	No show for scheduled office visit: charges based on office time reserved	$770/hr
0002	Broken appointment, with less than required two full *working* days' notice	$770/hr
0003	Patient–initiated prescription refill processing (pull patient chart, review medical record, write prescription or complete fax authorization, arrange for prescription pick up, make medical chart note) without accompanying office visit	$80
0005	Patient's insurance–initiated prescription prior authorization request processing by Dr. Mortimer	$80
0006	Returned ("bounced") check fee	$80

I have received a copy of this fee schedule: _____ Date:_____

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TELEHEALTH/TELEMEDICINE INFORMED CONSENT

I, _____ (name of patient) hereby consent to engaging in telehealth audio only medical/psychiatric services (also known as telephone consultations with Dale Mortimer, M.D.) as part of my medical/psychiatric treatment.

I understand that "telehealth or telemedicine" (also known as telephone consultations) includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio communications (also known as "using a telephone or cell phone").

I understand that, with my signed consent, telehealth may also involve the communication of my psychiatric/medical health information (orally) between Dr. Mortimer and/or his staff at the office of Dale B. Mortimer, M.D., P.C.

Technology: I understand that I will need a telephone, cell phone or satellite phone in order to make use of the telehealth/telemedicine services provided by Dr. Mortimer.

Location: I understand when participating in telehealth services with Dr. Mortimer that I must be at home or at a location appropriate and private enough for discussing medical/psychiatric concerns with Dr. Mortimer or his staff.

Financial Obligations: I understand that telehealth services are billed at the same rates as in–person care and my fee agreement applies to telehealth services. I understand that Washington State parity law mandates payment for medically necessary telehealth services at the same rates as in–person care under private insurance and state employee health plans. I understand that I am responsible for all fees not covered by my medical insurance company, including no–show fees.

Crisis Services: I understand that telemedicine appointments are considered outpatient medical/psychiatric services and are not intended as a substitute for emergency or crisis services. If I am experiencing a life–threatening medical/psychiatric emergency, I will either call 911, call my primary care physician, or present myself to the nearest hospital Emergency Services Department.

Video/Audio Recording: I understand that Dr. Mortimer will not record telehealth sessions (i.e., telephone or cell phone calls) without prior permission from me.

Confidentiality: The laws that protect the confidentiality of my personal medical information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. I also understand that there are both mandatory and permissive exceptions to confidentiality including but not limited to – reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, threats of violence, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of information from the telehealth interaction to other entities shall not occur without my written consent.

I understand that I have the following rights with respect to telehealth services with Dr. Mortimer and his staff.:

1. I have the right to withdraw my consent to participate in telehealth services provided by Dr. Mortimer at any time.
2. I understand that there are risks and consequences associated with telehealth including – but not limited to – the possibility, despite reasonable efforts on the part of Dr. Mortimer and/or his staff that: the transmission of my personal medical/psychiatric information could be disrupted or distorted by technical failures and/or the transmission of my personal medical/psychiatric information could be interrupted or intercepted by unauthorized persons or agencies (e.g., Homeland Security, the NSA, CIA, FBI or other three–letter federal agencies).
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured. In addition, I understand that telehealth–based medical/psychiatric services (i.e., telephone consultation with Dr. Mortimer) and care may not be as complete or comprehensive as in–person medical/psychiatric services. I understand that if Dr. Mortimer believes that I would be better served by other medical/psychiatric interventions, then I may need to schedule an appointment to meet with Dr. Mortimer in his office. I also understand that there are potential risks and benefits associated with any form of psychiatric/medical treatment, and despite my efforts and the efforts of Dr. Mortimer, my medical/psychiatric condition may not improve – and may even worsen.
4. I understand that once the current national health emergency caused by the COVID–19 pandemic has resolved, then the Washington Medical Commission (or other State of Washington agency) might capriciously and arbitrarily decide to prohibit either: (1) Dr. Mortimer from continuing to provide telehealth services to me; or (2) my medical insurance carrier from reimbursing Dr. Mortimer for his telehealth services (i.e., telephone consultations with me) at parity with in–office medical/psychiatric care.
5. I understand that I have a right to access my medical/psychiatric health information and request copies of medial records in accordance with Washington state law.

By signing this document, I agree that certain situations – including medical/psychiatric emergencies and crises – are inappropriate for telehealth services. If I am in the midst of a medical/psychiatric crisis or emergency, I should immediately call 911, my primary care physician or go to the nearest hospital Emergency Department. I understand that emergency medical/psychiatric situations may include: thoughts about self–harm, thoughts about hurting others, having uncontrolled psychotic symptoms, being in a life–threatening or medical/psychiatric emergency situation, or experiencing an overwhelming, irrational desire to believe ostensible political flapdoodle promulgated by the mass media or the Internet.

I have read and understand the information provided above. I have discussed telehealth with Dr. Mortimer or his staff, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and voluntary consent to medical/psychiatric treatment using this telehealth platform (i.e., telephone or cell phone communication with Dr. Mortimer or his staff).

_____ (patient signature) _____ (Date)