Contact, payment, consent Agreement

for services with W Slaughter MD ("Dr WS" below—[617] 233-8957)

Name:_____ DOB:_____ SSN:_____
(increasingly needed for insurance use)

Billing address:_____City;State/Provnc:_____;____Zip/Pstl Cd:_____
Your phone number, including for confidential messages (for instance, in case of cancellation):_____
Emergency contact person--where confidential emergency info can be left, should the very unlikely need ever arise:
Name: **Phone #:** Relationship:

If we are using health insurance to meet, please complete for our first meeting:

1. Primary insurance company:_____*and Secondary insurance company, if any:*_____
2. *If auth/referral required by your plan:* Referring MD:_____Auth./Referral #_____
   Total number of sessions allowed now:_____Start/Expiration dates:_____

AND→ ***bring*** *a* ***photocopy of BOTH (BOTH!—very important for billers' use) SIDES of your one or more current insurance cards to our first meeting and other forms as per instructions← Thanks!***

Credit card *(****offered as a convenience only; c.c. use may of course be started/changed/ended at any time****)*

Card type: DSCVR MstrCrd VISA *Nmbr:*_____ Exp date:_____

Circle **one** of these two options if credit card used→ ***1. copays only*** OR ***2. all fees I'm responsible for (copays, deductibles, missed sessions, etc)***

I authorize this signature to be kept on file for billing use.
Sign here ***only*** *if you've* ***circled*** *and* ***want to authorize one*** *of the types of credit card use just above:*

_____**X**_____

I acknowledge review of and agree, authorize and/or understand (that):

~..Dr WS/billing service encourage and are always welcoming of full discussion of billing issues, including delayed payments, payment plans, collections, cancellations due to economic hardship, etc;
~..Dr WS can respond to voice phone only (and US Postal Service mail, if desired), not texts, e-mail, fax, nor other communication routes (due to concerns re: confidentiality and promptness of response);
~..Dr WS is mandated to report many actual/possible/potential abuse/neglect/violence-type issues;
~..Dr WS may discuss my case in disguised form in confidential supervision/consultation without any protected health information or other very specific identifying information revealed;
~..Dr WS to disclose information to my insurance company/other authorized agency for claim processing, payment directly to Dr WS/billing agency, and use of a copy of this form in place of the original;
~..Dr WS will help--or on my own I can--transfer to another treater or get other opinions as I want;
~..due to the stand-alone nature of his practice, Dr WS may not be able to continue service if required to spend time for telephone/other complex authorizations such as insurance/pharmacy/other, and that I may be asked to clarify/facilitate any such procedures if needed, or transfer to another provider;
~.. due to the stand-alone nature of his practice, I myself—not my insurance company--am responsible for paying per the ***Privacy Practices and Fees Statements*** when canceling less than two business days beforehand (excluding weekends/holidays) or if I've not ensured authorizations are in place (timely cancellation may allow rescheduling the time; insurance will not cover these instances);
~..I must be in direct communication with Dr WS re: medication refills--not use pharmacy auto-refills;
~..I must use public emergency services (e.g., 911 or nearest hospital emergency services) if Dr WS/covering MD is not quickly available in an emergency including medication refills or otherwise;
~..receipt of Dr WS's ***Privacy Practices and Fees Statements*** form, having read that as well as this ***Contact, payment, consent Agreement,*** asked any questions, understand and agree to their current contents and to inform Dr WS/billing service of any changes to my information;
I consent to treatment with Dr W Slaughter.

Signature:_____Date _____ *Contact form oct 2022*