**South Lincoln Psychiatry, LLC**
**2001 Pine Lake Road**
**Suite 300**
**Lincoln, NE 68512**
**Phone: (402) 447-7221**
**Fax: (402) 447-7222**

Kelli D. Bremer, M.D., P.C.
Buda Psychiatry, PC

# OFFICE POLICIES

Thank you for selecting South Lincoln Psychiatry, LLC (SLP) which includes the entities of Kelli D. Bremer, M.D., P.C. and Buda Psychiatry, PC. We welcome you to our office.

In order to provide quality care we have provided you with these policies and information.

**By initialing the following you understand and accept these terms:**

____________**CLINICIANS:**
All clinicians at South Lincoln Psychiatry are independent providers and not employees of SLP.

____________**PATIENT REMINDER CALLS:**
This office will make all attempts to call and remind patients of their appointments, with this there may be times we are unable to complete this task. We take this time to remind patients that tracking appointments is ultimately your responsibility.

____________**MEDICATIONS:**
We must follow the rules and regulations of the DEA in prescribing medications. We aim to practice responsible medicine and “do no harm”, therefore, at times it may be necessary to take action or precautions against potential abuse or dependency of controlled substances.

____________**MEDICATION REFILLS:**
The most efficient way to request a refill of medication is to call your pharmacy. The exception to this is for ADHD/stimulant medication. Contact the office for refills of ADHD/stimulants Monday to Friday during regular business hours. We will respond to your refill request within 3 business days. No refills are available on evenings, weekends or holidays.

____________**CANCELLATION/NO SHOW APPOINTMENT POLICY:**
Consistency is essential for effective treatment; therefore, we ask that you keep your recommended scheduled appointment. If you are unable to do so, please give at least 24 hours advance notice. Failure to show for your appointment three times may result in termination of services. Patients who fail to show for their appointment without calling the office prior to the start of their appointment, will be considered NO CALL/NO SHOW (NCNS). A bill for $50 will be mailed directly to the patient. The NCNS fee WILL NOT be covered by insurance.

____________**COMMUNICATION/CONTACT WITH THE DOCTORS:**
Our staff will be available to help you during normal business hours (Monday-Thursday from 9am-4pm and Friday from 9am-1pm) at **(402) 447-7221**. If our staff is busy when you call or it is after hours, our voicemail will answer so that you may leave a message. Any messages left after 3pm Monday through Thursday and 1pm on Fridays will be returned the next business day. If your call is not urgent we will make every attempt to return your call within 24 hours with the exception of evenings, weekends, and holidays. If your call is urgent, but NOT an emergency, you may leave a voicemail message. This service however, is not guaranteed as we are an outpatient practice that does not have emergency services. Calls DO NOT substitute an office visit.

__________ Please note texting the office will NOT be monitored or utilized by the providers for communication. Please use voicemail only.

___________**IN AN EMERGENCY:**
Our office does not provide emergency services. If you find yourself in an emergency situation please CALL 911 immediately and/or go to the nearest emergency department.

___________**FINANCIAL POLICY:**
It is the responsibility of the patient to know if their insurance is "in network". If your insurance carrier is considered "out of network" or if you are not using insurance, full payment will be due at time of service. Our office will not file insurance claims to "out of network" insurance plans. If you choose to file the claim with your insurance yourself and need documentation or have questions, please contact Kari with our billing office at 605-881-5903.
Regardless of your insurance coverage, **all outstanding balances and copays will be due at time of service**. If appointment is via telehealth, it is your responsibility to call the office prior to appointment and pay co-pay and/or balance on account. If you are unable to make payment in full at time of service, call to make arrangements with billing prior to visit. Payment is expected **within 30 days** of billing once your insurance has paid. If requests for payments fail to settle an overdue balance, your account may be referred to a collection agency.

___________**SELF PAY AGREEMENT:**
You are responsible for all charges related to services provided by providers of SLP. At check-in new patient evaluations will pay $300 and follow up visits will pay $160 prior to visit. Additional charges may be billed based on complexity and/or time per physician billing after office visit completed.
If you have insurance coverage and are choosing not to use it, be aware that there may be other providers who are in network with your insurance company, and that if you were to see those providers, some/all of your bill could be covered by insurance benefits.

Self Pay Fee Schedule:

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|---|---|
| Outpatient initial evaluation | $300-385 |
| Follow up Appointment | $160- $315 |

_________**ADHERING TO THE TREATMENT PLAN**:
You're expected to follow the treatment plan which is developed collaboratively with you. This means being compliant with medications, keeping appointments and following through with referrals to therapists, other healthcare providers, or substance abuse treatment, etc.

_________**CONTINUATION OF SERVICES**:
Grounds for dismissal from the practice include abuse of medications, failure to follow your treatment plan, failure to follow office policies or procedures, no call no show 3 or more appointments, repeatedly rescheduling appointments, failing to pay your bill in a timely manner or being disrespectful to providers or the office staff.

If you have any questions regarding the above information, please call us at 402-447-7221 and we will be glad to discuss with you.

Thank you!

Dr. Bremer & Dr. Buda

I have read and agree to the terms and conditions listed above.

Print Patient Name: ________________________________________ Date of Birth:______________

Patient or Legal Representative Signature: ______________________________________
(If signed by other than patient, state relationship & authority to sign for patient)

Date: ____________________________