Giblin Consulting, Inc.
Markham S. Giblin, Ph.D.,Licensed Clinical Psychologist
Telephone: (541) 738-6516/Fax: (541) 738-6517
giblinconsulting@gmail.com/www.giblinconsulting.com

Corvallis Location:
1300 N.W. Harrison Blvd, Suite #140
Corvallis, OR 97330

MAILING ADDRESS
Eugene Location:
492 E. 13th Ave, Suite #201
Eugene, OR 97401

Welcome! Thank you for providing us with the opportunity to assist you. Please take a few minutes to read over and complete the attached forms.

Our office will check your insurance benefits and notify you of your copayment amount as well as any deductibles that your services here may be subject to. Please notify us immediately if your health care coverage changes at any point in time, so that we can inquire about your coverage and secure prior-authorization, if needed. Some plans will not retro-authorize even medically necessary services. Further, we may not be contracted providers with your new carrier. Still other plans may not have out-patient mental health benefits at all.

Some individual and some self-insured plans aside, most insurance plans no longer have limits on the number of mental health visits you may have in any given period of time.
If you have a co-payment based upon a percentage of allowable charges rather than a fixed dollar amount, we can convert that do a dollar amount for you (as it's based upon our contracted rate rather than our fee). ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE AND ARE PAYABLE BY CASH OR CHECK or CREDIT OR DEBIT CARD. Many times we are also able to charge an H.S.A. benefit card. Payment can be made over the phone, via our website, by mail, or in person at an appointment.

If you are unable to keep an appointment for any reason, please call with as much notice as possible but no later than 24 hours before the appointment to cancel. We will be happy to reschedule your appointment and offer your original appointment time to another client. PLEASE BE ADVISED THAT YOU WILL BE CHARGED AT THE FULL CONTRACTED RATE (NOT JUST THE COPAY AMOUNT) FOR FAILED APPOINTMENTS AND APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 24 HOURS NOTICE, EXCEPT IN CASES OF EMERGENCY.

The **Corvallis** office is located at 1300 N.W. Harrison Blvd., on the SW corner of Harrison and 13th Street (left-hand side of Harrison, far side of 13th). The building is a sage green with reddish trim. There is a parking lot JUST past the building on the left. You will want to be in the left hand land and waiting for it, as you may not see it until it is time to turn (there is generally a car parked on the street right up to the edge of the lot). The main door/entrance is on Harrison (front porch). The first left upon entering the building is the waiting room. Please have a seat there, and Dr. Giblin will come out to get you for your appointment. There will be no one to check-in with when you arrive.

The **Eugene** office is located at 492 E. 13th Ave., Suite #201, on the corner of 13th Ave and Ferry St, on the right-hand side of 13th (a one-way heading east), & just before the intersection of Ferry St.. It's located in The Wilcox Building, adjacent to the Bijou Theater. There is a parking lot JUST before the building on the right. You will want to be in the right hand lane so that you won't miss it. Return to the 13th Street sidewalk and follow the walkway into the entrance on the left Please follow the stairs to the second floor, turn to the left just after reaching the top. There will be an interior door to our wing of the building, and our office is the first on the right once through this door. If the door to Suite #201 is shut, please feel free to have a seat on the bench in the interior hallway.

Again, thank you for giving us the opportunity to be of assistance to you. Please don't hesitate to call the office or to speak with Dr. Giblin directly if you have any questions or require any other type of assistance.

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PROFESSIONAL DISCLOSURE STATEMENT

Professional Information, Ethics and Standards

I am a psychologist licensed by the Oregon Board of Psychologist Examiners. I identify and treat cognitive, affective, and behavioral conditions and symptoms of marital and family dysfunction. I apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families. As a licensed psychologist, I subscribe to the American Psychological Association Ethical Principals of Psychologists and the Oregon Code of Ethics. While no guarantee of results is possible, it is my responsibility to provide the highest possible quality of services to those who seek me out. I encourage you to ask any questions that you may have about my professional training, credentials, experience, and services.

Education and Training

I received my doctoral degree in clinical psychology (with an additional subspecialty in child and adolescent psychology) from the University of Georgia in 1988. I also completed a one year clinical internship training program at the University of Alabama at Birmingham Medical Center. I have met the necessary requirements for licensure as a psychologist as established by the Oregon Board of Psychologist Examiners.

Continuing Education

As a licensed psychologist, I am responsible for post-degree work relating to professional practice and the earning of at least 50 hours of continuing education credits every two years as specified by the Oregon Board of Psychologist Examiners.

Office Location

I currently have practices both in Corvallis and in Eugene. The business office is located in Eugene; all mail should be directed there. The phone and fax numbers, and email address is the same for both offices.

Fees

I currently charge two hundred and eighty dollars ($280) for an initial evaluation and one hundred and seventy-five dollars ($175) for a standard individual psychotherapy session of 45-50 minutes in duration. My fee for sessions between 25-30 minutes is one hundred and five dollars ($105). Current charges for couples and family sessions (45-50 minute duration) are two hundred dollars ($200). Fees for other services such as court appearances, hospital visits, case research and/or documentation, generation of special reports, and consultation with other professionals are typically based on a pro-rated charge for the actual time involved in providing the service, at the rate of two hundred and ten dollars ($210) per hour.

Payment

Statements of charges for services are sent out each month and are payable upon receipt. You are expected to keep your account current. Any unpaid bill over 60 days past due will be charged a financial charge of one and one-half percent (1½%) per month on the overdue balance. I reserve the right to use third-party collection procedures including legal action on overdue accounts; adequate notice will be given prior to the initiation of such procedures. We accept cash, check, credit cards (including many H.S.A. benefit cards). Payment can be made in the office, over the telephone, by mail, or through pay pal or credit card links on our website (giblinconsulting.com).

Insurance

This office will make every effort to aid you in obtaining insurance reimbursement to which you are entitled, including directly billing your insurance company if you so desire. If you choose to have this office do the insurance billing, please indicate this on the intake form and/or make arrangements directly with my office staff. We will be happy to answer any questions you may have concerning insurance coverage. In the event that you choose to do your own insurance billing,

please advise us so that your statements will include the proper information for direct submission to your insurance company. Regardless of insurance coverage, however, the responsibility to settle your account with this office remains yours.

Cancellations

Please give at least twenty-four (24) hours notice if you must cancel and/or reschedule an appointment. If you cancel your appointment with less than twenty-four (24) hours notice or fail to show up at the scheduled time, you will be charged the full contracted rate (not just the usual copay amount). Please note that insurance companies typically will not pay for such charges. Of course, if an emergency prevents you from keeping your scheduled appointment, you will not be charged. You may call the office at any time, day or night, to leave word of your cancellation.

Confidentiality

All work in this office is protected by State and Federal confidentiality laws. No information about you or your situation will be released without your explicit written permission. This is for your protection. Exceptions to this rule are as follows: 1) reporting imminent danger to client or others, 2) reporting suspected child abuse, 3) licensee consultation or supervision, 4) defense of claims brought against licensee, and 5) when you forfeit confidentiality in legal proceedings. It is the policy of this office to release information to your insurance company as necessary to process insurance claims you request us to make on your behalf.

Emergency Procedures

In the event of a crisis or emergency, please call the answering service (Paragon Communications) at 541-924-6501and state that it is an emergency. The answering service will contact me or my on-call colleague if I am unavailable (I am not always immediately available). This service is available twenty-four (24) hours a day. If you cannot wait for me or my colleague to return your call, you may call the Benton County Mental Health Crisis Service (541-766-6835, option 1) or the Sunflower House/Community Outreach Crisis Line (758-3000); both of these options are available 24 hours a day/7 days a week. Linn, Lincoln, Marion and other county residents should contact their local County Mental Health Department. Lane County clients, please call the White Bird Clinic at 541-687-4000, which is staffed 24 hours a day/7 days a week. In extreme emergencies, you should go to a hospital emergency room for treatment. Telephone calls in excess of ten (10) minutes will be charged at the hourly rate on a pro-rated basis (this does not apply to calls concerning appointment changes, billing inquiries or similar business). Again, please be advised that most insurance companies do not cover such charges.

Client Bill of Rights

(1) To expect that a licensee has met the minimal qualifications of training and experience required by state law;
(2) To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
(3) To obtain a copy of the Code of Ethics;
(4) To report complaints to the Board;
(5) To be informed of the cost of professional services before receiving the services;
(6) To privacy as defined by rule and law, including the exceptions to confidentiality of information obtained in the course of services that include the following:
   a) Reporting suspected child abuse,
   b) Reporting imminent danger to client or others,
   c) Reporting to relevant agencies,
   d) Licensee consultation or supervision,
   e) Defense of claims brought by client against licensee;
(7) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

State Board of Psychologist Examiners
895 Summer St. N.E.
Salem, OR 97310
(503) 378-4154

Questions

Please feel free to discuss with me any questions you may have concerning the details of these policies and procedures.

Rev 10/13

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FINANCIAL AGREEMENT

I, the undersigned, agree that I have read and I understand the Professional Disclosure Statement handout. In consideration of professional services rendered, I the undersigned, agree:

1. That I am responsible for all of the charges for services rendered to me or any member of my family;

2. That I will pay the amount charged for all treatment and other professional services rendered to me and my family;

3. That payment is due upon receipt of the statement of charges for services or when the services themselves are rendered, depending upon my agreement with my health care plan;

4. That although I may have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. Further, if for any reason any portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment of the bill;

5. That if I request and receive services for which my health insurance company will not agree to pay, I will be financially responsible for payment for those services;

6. That after my account is 60 days past due, I will pay a Finance Charge of one and one-half percent (1 ½%) per month (annual percentage rate of 18%), applied to any balance due over 60 days, after deducting current payments and/or credits appearing on the statement;

7. That I will pay all court costs, attorney fees, and/or collection fees which may be incurred in collecting my past due account; and

8. That the fee for services may periodically increase, that I will be notified in advance of any such increases, and that I will be responsible for paying for services at the increased rates.

X____ ______________________
Patient or Parent/Guardian Signature Date

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INFORMED CONSENT TO TREATMENT

This form is to document that I, ____, give my permission and consent to Giblin Consulting, Inc./Markham S. Giblin, Ph.D., to provide psychological services/psychotherapeutic treatment to me and/or ____, who is/are my child/children.

I have read and I understand the Professional Disclosure Statement and the Financial Agreement handouts. I understand that because of therapy or counseling, I (we/he/she) may experience emotional strains, feel worse during treatment, or make life changes that could be distressing. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed.

I acknowledge having received a copy of "Noticy of Privacy Practices".

I understand and have been informed of whom to call in an emergency or after office hours. I understand there is a charge for emergency contacts.

I understand that conversations with the therapist will almost always be confidential. I further understand that the therapist may report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has a legal responsibility to protect anyone I/we may threaten with violence or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I also understand that certain legal actions I may take may result in the release of my records by court order or request.

I understand that my health insurance company may maintain the right to inspect my records to assure that appropriate services are being provided.

I understand that a psychologist is not a physician and cannot prescribe or provide me with any drugs or medication or perform any medical procedures. If I believe I need medical treatment, I will choose a physician or ask for one to be recommended. I understand that my health insurance company's policy may only provide coverage for crisis-resolution. If this is the case, I understand that if I want to continue therapy sessions that are not authorized or approved by my health insurance company, I will be responsible for the cost of those sessions. If the cost of therapy presents a financial hardship for me, I will discuss this with my psychologist and make appropriate arrangements for payment or referral.

I understand that my questions about the process and progress of treatment are encouraged and always welcome. I understand that I have the right to stop therapy whenever I wish or to seek services elsewhere (including the right to ask for and receive referral resources).

X ____ ______________________
Patient or Parent/Guardian Signature Date

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INSURANCE INFORMATION

Name of Subscriber:____ Subscriber date of birth: ________________

Address of subscriber:____

Street City State Zip

Relationship of patient to subscriber:____________________________________ Subscriber's SSN: ___________________

Employer of subscriber: ____

Primary insurance company: ____ Phone #: ____________________________

Address of primary insurance: ____

Street City State Zip

Primary insurance identification #: ___________________________________ Group #: ____________________________

Secondary insurance company: ______________________________________ Phone #: ____________________________

Name of subscriber: ____ Subscriber date of birth: ________________

Address of secondary insurance: ____

Street City State Zip

Secondary insurance identification #: __________________________________ Group #: ____________________________

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to:
Giblin Consulting, Inc./Markham S. Giblin, Ph.D.
492 E. 13th Ave., Suite #201, Eugene, OR 97401
for services described as having been completed by him.

AUTHORIZATION TO BILL INSURANCE

I hereby authorize billing of my charges to my insurance.

AUTHORIZATION TO RELEASE INFORMATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical information necessary to process this claim to be disclosed to and acquired by my insurance carrier. Such information may be disclosed by my health care provider and will be used for the purposes of claims administration and evaluation, utilization review and financial audit. This authorization shall remain valid and effective from this date of signing until revoked in writing or until the claim has been paid. I understand I may request and shall be furnished a copy of this authorization.

X____ ___________________________

Signature of Patient or Guardian Date

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AUTHORIZATION TO DISCLOSE RECORDS AND INFORMATION

I, ______________________________, born on ____________, authorize Giblin Consulting, Inc./Markham S. Giblin, Ph.D. to

______ ☒ obtain from ______ ☒ provide to ____
Initials *Initials* *NAME OF PRIMARY CARE PROVIDER, PSYCHIATRIST, OR OTHER CARE PROVIDER*

a copy of my records as specified below. This information will be used on my behalf for the following purposes:

______ ☒ Further mental health/psychiatric care
Initials
______ ☒ Treatment Planning
Initials
______ ☒ Coordination of Care
Initials
______ ☐ Other: ____________________________
Initials

By initialing the spaces below, I specifically authorize the release of the following records in written form and/or via phone consultation, if such records exist:

______ ☒ All mental health records
Initials
______ ☐ Mental Health Intake Summary
Initials
______ ☐ Mental Health Treatment Summary
Initials
______ ☐ Mental Health Discharge Summary
Initials
______ ☐ Mental health progress notes
Initials
______ ☐ Psychological testing/evaluation records
Initials
______ ☐ Psychosocial Life History
Initials
______ ☒ Medical records
Initials
______ ☐ School records, including transcripts & testing
Initials
______ ☒ Drug/alcohol-related records
Initials
______ ☐ HIV/AIDS-related records
Initials
______ ☐ Other: ____________________________________
Initials
______ ☒ Re-release of medical, mental health, drug/alcohol-related, &/or school records from outside sources
Initials

If desired, the information to be released can be limited to a specific period of time:

______ ☐ This authorization is limited to information from the following time period: ______________________________
Initials
______ ☒ This authorization is not limited to information from a specific time period
Initials

I understand this authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

X____ ______________________
Signature of Patient (if 14 years of age or older) Date

X____ ______________________
Signature of Parent/Guardian (if patient is under 18 years of age) Date