

## Office and Financial Policy for Omega Mental Health 2026

*Please carefully read and initial each statement. You may request a copy for your records*

1. Be aware that Omega strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy and will be notified if you seek controlled substances elsewhere. We require only 48-72 hour notice on controlled substance prescriptions. We will also require random Urine Drug Screens for any patients receiving controlled substances. **Any requests made prior to a maximum of 3 days early may be cause for termination of care by our office, regardless of the reason for the early request, without exception.** \_\_\_\_\_
2. I understand that the staff at Omega adheres to the rules and policies of the company and will try their best to help with any situation. I understand that any abusive or aggressive treatment or language directed at staff or providers may be grounds for termination. \_\_\_\_\_
3. I understand that if I 'no show' I will be charged 100% of my scheduled appointment time. I understand that if I 'late cancel' (cancel without 24 hr notice), I will be charged 50% of my scheduled appointment time. I understand that this fee is **NOT** covered by insurance. I also understand that if my account receives more than three missed appointments that my services may be terminated, and my care referred elsewhere, without exception. \_\_\_\_\_
4. I understand that arriving late for my appointment may be considered a 'late cancelation', and in some cases a 'no show', depending on when you show. Anything over half of the appointment time, your provider may not be able to see you, and there could be a charge for the missed appointment. \_\_\_\_\_
5. I understand that co-payments and patient portions are due at the time of service and are dictated by the insurance companies. Failing to collect this payment is a violation of our agreement with your insurance company. Additionally, any patient balance that reaches 60 days will be charged a 1.5% interest rate compounded monthly. Also, balances that reach 60 days or over without contact/ payment will be transferred to collections and care will be terminated. \_\_\_\_\_
6. I understand that it is my responsibility to contact my insurance company to verify benefits, provider contracting status, and authorization for treatment guidelines prior to my appointment. **Although our providers do contract with many insurance plans, they may not be contracted with yours.** \_\_\_\_\_
7. I understand that if I request forms to be filled out without an appointment, there is a fee for this service, and that fee depends on the length of time it takes my provider to complete the forms. I also understand that **I must follow up as directed and keep my account current or Omega will be unable to complete my forms.** \_\_\_\_\_
8. I understand that calling the after-hours answering service for **non-urgent issues such as routine prescription refills and scheduling questions** may result in a fee being assessed to my account. I also understand that **excessive calling may result in a charge on my account**, and the charge is at the discretion of my provider. \_\_\_\_\_
9. I understand that if the patient is a child or adolescent, I am solely responsible for the account regardless of divorce or custody. It will be my responsibility to collect from any other parties involved. \_\_\_\_\_

Preferred Pharmacy and Location: \_\_\_\_\_

I have read, understood, and agree with all the above listed consents and disclosures. Please know that **regardless of signature or initials on this page all office policies will still be enforced.**

**For:** \_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
SSN

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Apt #

\_\_\_\_\_  
Email

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

(\_\_\_\_\_) \_\_\_\_\_  
Best Contact Phone