**Office Policies and Signed Informed Consent**

Welcome!Please read the following information regarding evaluation, treatment goals, confidentiality, and office policies.

 **Treatment Goals:**

My goal is to help you identify and ameliorate obstacles to optimal mental health. You are expected to play an active role in creating our treatment plan and assessing progress. Your first appointment is a consultation and involves a comprehensive evaluation of your medical, psychiatric, social, and developmental history. With your permission I may communicate with your other treating physicians if necessary. You are responsible for attending scheduled appointments, taking agreed upon medications as prescribed (if medication is indicated), and helping to obtain prior treatment records including lab reports when necessary. If we determine that your needs would be better met in a different treatment setting, I will provide the necessary information and referrals.

 **Appointments:**

The initial consult appointment is 90 minutes in length and routine appointments are 45-50 minutes in length. Office hours are by appointment only. The frequency of appointments varies as acuity dictates and can be as often as weekly or as infrequently as every 3-4 months. To reach me, please leave me a voicemail (not a text because it is a landline). One of the psychiatrists in my call group will cover my practice for urgent clinical matters if I am away. However, if you have an emergency, please call your local emergency room, or call 911.

 **Payments:**

Payment is due at the time of the appointment. The fee for the initial consult is $475, and the fee for all other appointments is $350. Credit card authorization is kept on file for all patients and is the default method of payment. You will be provided with a superbill to submit to your PPO insurance carrier for reimbursement. Fees will increase by 5% on Jan 1st of each year. I provide free care to several families in need rely on those paying the regular fee to cover that cost. However, if at any point your financial circumstances change, please let me know.

 Initial \_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_ over 🡪

 **Cancellations and Missed Appointments:**

You will be billed the **full fee** for sessions that you cancel with less than 24 hours’ notice. You may leave cancellation voicemails at any time on the office landline (310) 373-9464

 **Confidentiality:**

Issues discussed in treatment are private and will not be discussed with anyone including other treating physicians, therapists, or family members without signed consent. Treatment notes are generally legally protected as both confidential and ‘privileged’. However, there are limits to the privilege of confidentiality including:

1) Suspected abuse or neglect of a child, elderly person, or a disabled person

2) When your psychiatrist or therapist believes you are in danger of harming yourself or

 another person or are unable to take care of yourself.

3) If you report that you intend to physically injure someone

4) If the psychiatrist is ordered by a court to release information as required by law

5) When your insurance company is involved, e.g., prior authorizations for medications

6) In natural disasters whereby, protected records may become exposed

 **Record Keeping:**

An electronic clinical chart is maintained for treatment, billing, and medical-legal purposes. It describes your condition, your treatment plan including medications, progress in treatment, and billing codes for sessions. Your records will not be released without your written consent, with the exceptions outlined above.

 **Consent for Evaluation and/or Treatment:**

By signing below, you are stating that you have read and understood this 2-page policy statement and you have had any questions answered to your satisfaction.

I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_