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PSYCHIATRIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Treatment Philosophy-Explanation of Psychiatric Treatment

My role as your psychiatrist is to gain necessary information from you about your medical and mental health so that I can make a diagnosis. I will then discuss with you my recommendations as to whether psychotropic medications may be helpful in remediating your symptoms. We will discuss possible side effects, how the medications works, dosages, and other questions you may have. It is important that you call me if you have uncomfortable levels of side effects, if your symptom pattern changes in a negative way, if your medical health changes, or if any other physician prescribes to you any other medications. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

Initial here:_____

Limits of Confidentiality

All information between a psychiatrist and a patient is held strictly confidential. Please refer to the Notice of Privacy Practices you have received with this form. Please note that I may make disclosures in the following situations:

1. When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
2. When the patient communicates a threat of bodily injury to others.
3. When the patient is suicidal.
4. When disclosure is required pursuant to a legal proceeding.

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, neither your name or other identifying information about you is revealed. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your clinical record.

You should be aware that I practice in a group multidisciplinary practice, (and in the same suite with other mental health professionals, wherein we each practice independently). In addition, I employ clerical staff. In some cases, I may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.

I also have a contract with Physicians Billing and Consulting Service (PBCS). As required by HIPAA, PBCS is required to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law.
Please note that once confidential information is released, this office no longer controls the confidentiality of that information. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. Please be advised that conversations occurring on a cellular or cordless telephone are not always secure; therefore, confidentiality cannot be guaranteed.

If your treatment is being covered by a mental health insurance or EAP benefit, this office may be required to provide (by telephone, mail or fax) clinical information to obtain payment and/or authorization for treatment. Information provided to the insurance company or managed care organization for the purposes of billing and/or obtaining additional treatment is no longer under the control of this office; therefore, confidentiality of the information cannot be assured.

Initial here:_____

Release of Information

I (the patient) authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Initial here:_____

Contacting Me/Emergency Access

Due to my work schedule, I am often not immediately available by telephone. I am usually in the office one or two days per week. I will not answer the phone when I am with a patient. My telephone is answered at all times by a receptionist or a confidential voice mail system that is monitored frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

Practitioners are available after hours to handle emergencies. By calling my voicemail, (714) 578-0990, you can leave a confidential message at any time. If you have a very urgent situation, you can also page me or the therapist on call by calling my answering service at (626) 859-4150. All calls are returned as soon as possible. Please be advised that if your emergency is of a life-threatening nature, you should call 911. Please be advised that conversations occurring on a cellular or cordless telephone are not always secure; therefore, confidentiality cannot be guaranteed. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initial here:_____

Professional Fees

My fee for the initial diagnostic interview is $180.00. My regular fee is $85.00 for a medication check session. I also charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations **lasting longer than 5 minutes**, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulties of legal involvement, I charge a minimum of $250.00 per hour for preparation and attendance at any legal proceeding.]

Initial here:_____

Financial Terms: Insurance Coverage and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by

your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

Co-payment amounts are set by your benefit plan. **These payments are due and payable at each appointment**. Information regarding the co-payments set by your insurance plan for each visit will be provided to you or you may contact your health plan or our billing service, PBCS, for this information.

For special modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and this office/practitioner. This agreement should outline your understanding that it is not a covered benefit and should cover fees and the treatment plan you may expect.

At any time during treatment should you become ineligible for insurance coverage, you will notify the practitioner and understand you will become responsible for 100% of the bill.

Initial here:_____

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your method of payment is by credit card, you hereby authorize the doctor's office to receive payment from your credit card company.

Should this account become delinquent and sent for collection, any reasonable legal fees, court costs, collection agency fees, or any associated costs, fees or penalties will be added to the balance. It is understood that in the event your portion of the balance due becomes 90 days or more delinquent, a late fee of $15.00 per month will be charged until the amount you owe is paid in full. There will be a $15.00 charge on all returned checks. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

Initial here:_____

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed according to the scheduled fee and instructions of the benefit plan. Repeated "no-show" appointments could result in referring you back to the insurance or managed care company for reassignment to another practitioner. Your insurance company will not be billed for fees associated with missed or canceled appointments.

Initial here:_____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_____ _____/_____/

Patient or Guardian Signature Date

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED BY JOE F. CHIU M.D.

_____ _____/_____/
Patient or Guardian Signature Date

Consent for Treatment

I (the patient or guardian) authorize and request my practitioner to carry out psychiatric exams, prescribe medication, and provide psychiatric treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this may be a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. It is also possible that psychiatric medication prescribed may have uncomfortable side effects.

_____ _____
Patient/Guardian Signature Date

_____ _____
Practitioner Signature Date

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent. I understand that my child is the identified patient and that other family members who may participate in his or her treatment are not considered to be a patient for purposes such as confidentiality or continuity of treatment.

I understand that privacy and trust between my child and the practitioner are necessary for psychotherapy to be effective and that the practitioner, using sound professional judgment, will release information to me only if determined to be critical to my child's mental and/or physical well-being.

Patient Name

_____ _____ _____
Signature of Legal Guardian/Legal Representative Relationship to Patient Date

_____ _____ _____
Signature of Legal Guardian/Legal Representative Relationship to Patient Date

_____ _____
Practitioner Signature Date