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Child & Adult Psychiatrists of the Peninsula, Inc. (CAPP)
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OFFICE POLICY STATEMENT

Welcome. As we begin our work together, it is important that you have some information about treatment and the operation of this office. We are working together to address your concerns. Psychotherapy and psychiatric treatment work best with open communication. These are some basic guidelines for our work together.

APPOINTMENTS

Regularity and continuity are key features of therapy. All sessions are by appointment only. Psychotherapy sessions are scheduled for 50 minutes. Medication visits are usually 25 minutes. Sessions cannot be extended if you arrive late.

CANCELLATION POLICY

Your scheduled time is reserved for you. Please notify me as soon as you become aware that you will be unable to keep an appointment. *A minimum advance notice of 48 hours is required for cancellation or rescheduling without charge. Unless I receive such notice, you will be charged the full fee for missed or cancelled sessions.* Please be aware that most insurance companies will not reimburse for sessions missed or cancelled without adequate notice, making you responsible for the entire session fee.

EMERGENCIES

In general, you should contact me with questions about your treatment or condition. I check my voice mail messages at regular intervals during the business day (Monday through Friday). In an emergency, first leave a message at my office phone, 650-375-8077. Then call me at my urgent number, 650-740-9280. However, if you have an emergency and cannot wait to reach me, you should call 911 or go to the nearest emergency room.

FEES

My regular fee of $_____ is based on a 50-minute session. The $_____ fee for an 75-minute intake session includes the initial review of medical or school records and collateral phone contacts as indicated. Children and adolescents under the age of 18 years require *two* intake sessions—one primarily with the parent(s)/guardian(s) and one primarily with the child/adolescent. Each of these two sessions is typically 60 or more minutes at a rate of $_____ per 60 minutes. Longer evaluation sessions are prorated according to this rate. The fee for a 25-minute medication management visit is $_____. Shorter or longer medication or therapy visits are billed in proportion to my regular fee. I do not charge for brief telephone contacts; however, I do bill in proportion to my regular fee for telephone contacts necessitating more than 5 minutes. If requested to write a summary letter or report, I bill for the time involved at my regular rate. Fees are subject to change.

Initials _____

PAYMENT

In order to reduce the costs to you as well as to meet your obligations to your doctor, you are requested to pay at the time of each session. If you have arranged with me to be billed, you will be billed monthly with payment due upon receipt of each statement. *Please refer to the Patient Financial Responsibility Agreement, which you signed upon registration for specific terms of your agreement.* You are financially responsible for any charges denied or not covered by insurance. Defaulted accounts will be sent to collection.

RELEASE OF INFORMATION TO YOUR INSURANCE COMPANY

If you are using your insurance to pay for your treatment, you are giving permission for us to release treatment information such as name, diagnosis, date and type of service, etc. to insurance or managed care companies to facilitate reimbursement. Additionally, name and diagnosis may be given to diagnostic laboratories (including Lab Corp, Quest Diagnostics or hospital–based labs such as Stanford, Mills-Peninsula, etc.) to facilitate billing for services they provide to you. Please refer to our HIPPA notice.

LIMITS OF CONFIDENTIALITY

Unless you give explicit authorization for release of information, your treatment is strictly confidential. However, under California law and HIPPA (see our notice of HIPPA for further details) there are exceptions. Please see examples below:

1. When I am on vacation, another psychiatrist will cover my practice. The doctor may be informed about you and will maintain confidentially as per law.
2. California state law requires the doctor to disclose patient information to outside agencies or third parties in cases involving:
   a. If you pose an imminent danger to yourself or others
   b. If you are unable to take care of your basic needs because of mental illness
   c. In cases of suspected child or elder abuse
   d. Under certain circumstances when ordered by a court

If you have any questions or concerns regarding these issues, I encourage you to discuss them with me. I look forward to our work together. Thank you.
I have read and agree to the above.

Guarantor signature: _____
Date: _____

I CERTIFY THAT I HAVE BEEN PROVIDED INFORMATION ABOUT, AND A WRITTEN COPY OF, THE CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA (CAPP) NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (HIPPA) AND HOW THIS PERTAINS TO PROTECTED HEALTH INFORMATION (PHI)		
Guarantor Signature	Relationship to patient	Date