PACIFIC MENTAL HEALTH

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IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION & INITIAL

CONFIDENTIALITY

I understand that all information between myself and Dr. Yuan is held strictly confidential and no information about my psychiatric and psychological services including diagnosis, treatment, prognosis, progress or any other confidential information will be released unless permitted by law or:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/Elder abuse or neglect is suspected,
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As necessary for continuity of care,
7. I fail to make regular payments on my outstanding bill which could result in information being forward to a collection agency.

I understand that in cases 2, 3 and 4, Dr. Yuan is required by law to inform potential victims and legal authorities so that protective measures can be taken. *This clinic follows the "minimum necessary" rule for release.*

_____ **(please initial)**

RELEASE OF INFORMATION & KEEPING HEALTH INFORMATION CURRENT

In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other health care providers and facilities for purposes of diagnosis and treatment. It is my responsibility to keep my doctor informed of changes to my health that can affect treatment. (Release of information **to** providers, family, etc, requires a separate form.) _____ **(please initial)**

GRIEVANCES

I acknowledge that I may submit a grievance to Dr. Yuan at any time to register a complaint about any aspect of my care. **NOTICE TO CONSUMERS- Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322** www.mbc.ca.gov _____ **(please initial)**

GENERAL CONSENT FOR TREATMENT

I voluntarily authorize and request Dr. Yuan to carry out psychological examinations, treatments, and or/diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that Dr. Yuan will keep a clinical record that will contain information regarding my diagnosis, treatment, prognosis, progress, and other documents pertinent to my treatment. This record is confidential and will only be released with my written consent except in cases detailed under "Confidentiality" _____ **(please initial)**

EMERGENCY PROCEDURES

I understand that my provider may not be available for emergencies due to clinic or other responsibilities. *If an emergency or life threatening situation arises*, I will follow the emergency procedures as follows: *I will call 911 or go to my nearest Emergency Room or call a telephone Crisis Line at* **1-800-273-TALK.** For urgent situations or distress, such as medication side effects, I will call Dr. Yuan and leave a message. I understand that calls will be returned periodically through the day and to call again if I do not receive a response within 24 hrs. If my call is not promptly returned and I require immediate attention, I will follow the above emergency procedures. _____ **(please initial)**

APPOINTMENTS & FINANCIAL POLICIES

Initial visits are extensive and usually 1-1.5 hrs. Initial evaluations cost $350. Follow up Visits are as follows: Psychotherapy sessions with/without medication management **50 minutes** at $300/session. Follow up **25 minute** sessions for brief therapeutic interventions, medication management, paperwork requests are $165/session (typically for patients seeing another provider for therapy). _____ **(Please Initial)**

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This practice does NOT contract with insurance providers. Health plans can restrict authorizations for effective and beneficial treatments and I choose to practice such that your best interests rather than those of an outside party are pivotal to my decision making. Your health history is confidential and insurance companies can use information to set health, life, and disablity rates or even reject you for coverage later in life. If you choose to utilize your insurance for coverage, you can be provided an invoice (superbill) which you can submit to your insurance for reimbursement.

Payment for services provided is collected at the time of the appointment. Payments can be rendered in **cash or check** made out **to Pacific Mental Health.** I understand that I will incur a service charge of $10 for any balance not paid and for every month my bill is unpaid. I understand the charge for a bounced check is $20**. _____ *(please initial)***

FEES FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS:
Please be on time for appointments. My appointment time is reserved for me to meet with Dr. Yuan. If I am more than 15 minutes late, I have missed my appointment and need to reschedule in order for my provider to deliver safe and effective care to me and subsequent patients on that day. I understand there is a **24-hour cancellation policy** and that I will be billed **in full** for missed appointments. I understand Dr. Yuan has very limited availability and early notification allows other patients to utilize that time. _____ **(please initial)**

REQUEST FOR RELEASE OF RECORDS
If I sign to request my records to be released, I understand that these records may be released in the form of a summary. I understand I will need to meet with my provider to discuss information that will be released. _____ **(please initial)**

PRESCRIPTIONS & REFILL REQUESTS:
If I am receiving prescribed medication, it is imperative that I attend regular follow up visits for Dr. Yuan to monitor my progress and potential side effects. I will contact my doctor with any concerns or questions requiring immediate attention. Self discontinuation of medications can result in consequences my doctor may be unaware of and put me at risk. In general, refills will only be given at appointments. In special circumstances or if I need to reschedule my appointment, I may receive a refill to last me until my next scheduled appointment. I will need have my pharmacy make a request 5-7 days before my medication runs out. _____ **(Please Initial)**

HOW TO MAKE THE MOST OUT OF YOUR CARE
Dr Yuan values patient education and emphasizes this in her practice. Patients are encouraged to ask questions and to take an active role in their education and care to enable self empowerment. Patients will be educated on the signs and symptoms of their diagnosis, treatment options, and the indications, benefits (mechanisms of action) and risks (from common minor side effects to rare serious or life threatening adverse effects) in order to help them choose the treatment that is most beneficial and best suited to them. Understanding potential adverse effects can seem frightening but allows patients to monitor and identify early warning signs to prevent negative outcomes and optimize chances for successful treatment. Although every attempt will be made to ensure questions are answered, time constraints and volume of information make it difficult to provide an "all inclusive" education. Patient will thus be offered resources for self directed learning and encouraged to make lists of issues they wish to address at appointments. It is understood you are engaging in treatment as an outpatient and therefore are consenting to utilize Dr. Yuan's services by showing up at appointments. If recommended and you choose to take medication as part of your treatment, consent is verified when you actively acknowledge a prescription and take the medication on your free-choice. _____ **(please initial)**

Withholding information from my doctor can increase risk for complications, life threatening interactions, and prolonged course of illness. I understand that if I would like to make changes to my treatment between appointments, I need to come into the office and be seen in person. I will call to make a sooner appointment. I am aware that Dr. Yuan may be available by phone in matters of immediate concern however, in order to provide the highest quality of care, no treatment will be discussed at length over the phone or email. I will make every attempt to be present for my scheduled appointments. I understand that a returned phone call by my provider does not take the place of a session and I may be required to schedule a follow up appointment for safe and effective management of my condition._____ **(please initial)**

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I understand that Dr Yuan has the right to refuse to continue as my healthcare provider if my care is being compromised by treatment non-adherence, lack of follow up, engaging in behaviors or other issues which are detrimental to my health and treatment. I would be notified of necessary changes if something like this should occur and will be offered referrals to other providers if I am unable to adhere to the guidelines of the recommended course of treatment. **Abuse of any of the medications or services provided can result in termination of care. _____ (please initial)**

RELEASE TO EXCHANGE INFORMATION

If there are individuals that you would like me to have communication with please provide the names of people with their phone numbers below. This enables me to have communication with them. If there are limitation as to what I am able to talk about please write it below. As a patient you have the right to discontinue content/release of information without fear penalty or retaliation.

1)Name:_____
Address:_____
Phone:_____

2)Name:_____
Address:_____
Phone:_____

3)Name:_____
Address:_____
Phone:_____

Emergency Contact _____Relationship_____
Telephone # _____
This would only be utilized in emergency situations.

If questions arise at any time regarding policies of the practice, confidentiality or other treatment issues please ask. As a consumer, you have the right to be informed.

I hereby declare that I am voluntarily seeking treatment under the care of Tara Yuan, M.D. I acknowledge and accept the notifications of the disclosures, policies, and treatment guidelines of Dr. Yuan's practice.

Signature_____Date_____
(Patient Signature) Patient Name, printed

Signature_____Date_____
(Legal Parent/ Guardian Signature,) Legal Parent/ Guardian Name printed