KATHERINE CHEMODUROW M.D. • ANISHA PATEL-DUNN, D.O. • UDI ZAKEN, M.D.

PACIFIC COAST PSYCHIATRIC ASSOCIATES, INC. 2019 Webster Street, San Francisco, CA 94115
T (415) 409-0944 **F** (415) 447-8665

NEW PATIENT ENROLLMENT

Please read and complete each of the documents listed below as completely as possible. These documents are intended to be resources for you, as well as aides to us for your care and treatment.

Enclosed please find the following documents for you to carefully review and complete:

- New Patient Registration
- Checking Your Outpatient Mental Health Insurance Benefits
  - For your convenience, this document is provided to assist you when calling to check your health insurance benefits prior to your first visit.
- Authorization to Release Information for Treatment, Billing, or Healthcare Operations
  - Authorization is not required for treatment. However, it may be required for sending your insurance company additional information requested for claims processing.
- Assignment of Benefits
  - Assignment of benefits is not required for treatment. However, it is required if you would like us to bill your insurance company for you.
- Health Insurance Information
  - In order for any claims to be submitted to your health insurance company this document <u>must be</u> completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).
- PCPA's Notice of Privacy Practices and Policies
- PCPA's Notice of Office Policies and Procedures
- Combined Acknowledgement of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notice of Office Policies and Procedures

You may keep the Notice of Privacy Practices and Policies and Notice of Office Policies and Procedures for your reference. Please feel free to request copies of any other forms.

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NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: ______________________ DOB: ____________ Sex: ______

Mailing Address: ______________________________

City, State, ZIP: ______________________________

SSN: ______________________ Employer: ______________

Home Telephone: ______________ May we leave a message? Yes ✐ No ✐

Work Telephone: ______________ May we leave a message? Yes ✐ No ✐

Cellular Telephone: ______________ May we leave a message? Yes ✐ No ✐

E-mail: ______________ May we send a message? Yes ✐ No ✐

____

MEDICAL AND REFERRAL INFORMATION

Complete Name of Primary Care Provider: ______________________

Primary Care Provider's Telephone Number: ______________________

Complete Name of Referring Physician: ______________________

Referring Physician's Telephone Number: ______________________

Name of Pharmacy: ______________________

Pharmacy Telephone: ______________ Pharmacy Facsimile: ______________

Who referred you to our practice? ______________________

EMERGENCY CONTACT

Who should we contact in case of an emergency? ______________________

Relationship to you: ______________________

Home Telephone: ______________________

Work Telephone: ______________________

Cellular Telephone: ______________________

Other: ______________________

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CHECKING YOUR OUTPATIENT MENTAL HEALTH INSURANCE BENEFITS

Health insurance plans vary in the kinds of outpatient mental health services they cover. Please contact your health insurance company to check on your benefits and eligibility. Important questions to ask about your coverage are listed below. Please bring this completed form with you to your first appointment along with your health insurance identification card.

Telephone number to call to check my benefits and eligibility: ____________________________

Is there another number I must call to check my eligibility and benefits?.........Yes No

If yes, the telephone number I must call: ________________________________

Does my insurance cover outpatient mental health services? …………………………...Yes No

Is my health insurance coverage *active*? ....Yes No

If yes, my policy became effective on: ____

Are my mental health benefits based on a calendar year? …………………………….....Yes No

If not, my benefits are based on this range of dates: _____________________________

How many outpatient mental health *visits* are covered for one (1) year? ________________

How many rem*aining visits* do I have for the current year? _______________________________

Is the doctor, a "pref*erred*" or "in-*network provider*" for my health insurance plan? (Please be sure to specify the practice address of 2019 Webster Street.) .... Yes No

For the doctor's services:

Do I pay a *co-pay* for each visit? .... Yes No

If yes, my co-pay amount for each visit is: _____________________________________

Do I have a co-*insurance* cost for each visit (a percentage of the charge that I have to pay myself)? .... Yes No

If yes, my co-insurance percentage for each visit is:

Do I have to obtain an *authorization* for the doctor's services? …………………………..Yes

No

If yes, who must call? …………………….. My referring provider Myself Doctor

The number to contact to obtain an authorization is: __________________________________

Please be sure to bring this form with you to your first appointment. Thank you.

Patient Name: ____________________________________ **Date:** ______________________

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

You are not required to give this authorization. However, claim charges denied due to a failure to provide requested documents (due to a lack of authorization) will be the responsibility of the patient.

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that PCPA reserves the right to change notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and PCPA's practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that PCPA and support staff have already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize PCPA to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

*Th*e patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.*

Patient Signature: ______________________ **Date:** ______________

Patient Printed Name: ______________________________

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: ______________________ Relationship to Patient: ______________

Signature: ______________________ Date: ______________

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ASSIGNMENT OF BENEFITS

I hereby assign to PCPA my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to PCPA. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by PCPA.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Patient Signature: ______________________________ **Date:** ____________________

Patient Printed Name: ____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: ______________________________ Relationship to Patient: ________________

Signature: ____________________________________ Date: ____________________

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HEALTH INSURANCE INFORMATION

In order for any claims to be submitted to your health insurance company the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).

PRIMARY HEALTH INSURANCE

Primary Insurance Company: ______________________________

Insurance Company Telephone: ______________________________

Insurance Company Address: ______________________________

City, State, ZIP: ______________________________

Patient's Relationship to Subscriber: ✐ Self ✐ Spouse ✐ Child ✐ Other: ________

Patient ID: ______________________ Patient Birth Date: __________

*Subscriber on Policy: ______________________________

Subscriber ID: ______________________ Subscriber Birth Date: __________

Subscriber Insurance Group #: ______________ Subscriber SSN: __________

Subscriber Address: ______________________________

THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: ______________________________

Insurance Company Telephone: ______________________________

Insurance Company Address: ______________________________

City, State, ZIP: ______________________________

Patient's Relationship to Subscriber: ✐ Self ✐ Spouse ✐ Child ✐ Other: ________

Patient ID: ______________________ Patient Birth Date: __________

*Subscriber on Policy: ______________________________

Subscriber ID: ______________________ Subscriber Birth Date: __________

Subscriber Insurance Group #: ______________ Subscriber SSN: __________

Subscriber Address: ______________________________

THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.

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NOTICE OF PRIVACY PRACTICES AND POLICIES, *EFFECTIVE JULY 1, 2006*

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by PCPA whether created by myself, my personnel or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information (PHI) (information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the following categories.

A. DISCLOSURES WHICH REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or healthcare operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents and business associates of the practice. The definition of health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. Therefore, if you would like information submitted to one of these companies, an authorization will be required, unless I am otherwise required by state or federal law.

B. ROUTINE SITUATIONS

1. **For Treatment** I may use information about you to provide you with medical treatment or services. Treatment is when I provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when I consult with another healthcare provider, such as your primary care physician.

2. **For Payment** I may use and disclose information about you so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company, or a third party (including a collection agency if necessary). For example, I may give your health insurance plan information about services you received at the practice so your health insurance plan will pay my practice or reimburse you for the services. I may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

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3. **For Healthcare Operations** I may use and share information about you for administrative functions necessary to run my practice and promote quality care. I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services. I will contractually bind these third parties to protect your information as I would. Also, I may permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

4. **Communicating with You and Others Involved in Your Care** My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

C. SPECIAL SITUATIONS

1. **As Required By Law:** I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid court subpoena.

2. **Health Oversight Activities**: I may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

3. **For Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that you have received within my practice and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena requiring provision of such information of which you have been properly notified and in response to which you have not opposed the court subpoena within the legally specified format and timeframe, or in the instance of the issuance of a court order compelling me to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

4. **To Avert Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I believe reasonably that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threat of harming another individual may be reported to appropriate authorities.

5. **Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the California Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

6. **Public Health Risks:** I may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:
   a. To prevent or control disease, injury, or disability
   b. To report child abuse or neglect
   c. To report adult and domestic abuse
   d. To report reactions to medications or problems with products
   e. To notify people of recalls of products they may be using
   f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
   g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

7. **Law Enforcement**: I may release information about you if asked to do so by a law enforcement official:
   a. In response to a court order, subpoena, warrant, summons, or similar process
   b. To identify or locate a suspect, fugitive, material witness, or missing person
   c. If you are suspected to be a victim of a crime, generally with your permission
   d. About a death we believe may be the result of criminal conduct
   e. About criminal conduct at the hospital
   f. In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

YOUR RIGHTS AS A PATIENT

In addition to provisions by the practice to protect your confidential information, you are entitled to six (6) specific rights as a patient. Request forms are available for your assistance at Pacific Coast Psychiatric Associates Inc.

1. **You have the right to request restrictions on certain uses and disclosures.** You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing to me. In your request, you must tell me: (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want it to apply. I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

2. **You have the right to receive confidential communications.** You have the right request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing to me. Your request must specify how or where you wish to be contacted. I will not ask you the reason for your request. I will seek to accommodate all reasonable requests.

3. **You have the right to inspect and obtain copies.** You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding; and confidential information related to certain laboratory tests under Clinical Laboratory Improvement Amendments (CLIA). To inspect and copy information that may be used to make decisions about you, you must submit your request to me in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances I may deny your request to inspect and copy information:
    a. I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person
    b. The information makes reference to another person (unless the other person is a healthcare provider) and I have determined, in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to the other person
    c. The request for access is made by your representative and I have determined, in the exercise of professional judgment that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person. If you are denied access, you may request a review of the denial by another licensed medical practitioner. I will comply with the outcome of the review.

4. **You have the right to amend confidential information.** If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request and a reason that supports your request must be made in writing and submitted to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:
    a. Was not created by my practice, unless the person or entity that created the information is no longer available to make the amendment. In such instances I would consider the request
    b. Is not part of the information kept by or for my practice
    c. Is not part of the information which you would be permitted to inspect and copy
    d. Is accurate and complete

5. **You have the right to receive an accounting of disclosures of confidential information.** You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to me. Your request must state a time period that may not be longer than six (6) years and indicate what format you want the list (for example on paper or in an electronic file). The first list you request will be free. For additional lists, I may charge you the cost of providing the list. I will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:
    a. To carry out treatment, payment and healthcare operations
    b. To individuals of confidential information about them
    c. As a result of assigned authorization
    d. For the practice's directory or to persons involved in your care
    e. For national security or intelligence purposes; or
    f. To correctional institutions or law enforcement officials

6. **You have the right to obtain a paper copy of this Notice upon request.** Even if you have requested an electronic copy, I will provide you with a paper copy of this Notice at your request.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. I will promptly revise and distribute my Notice whenever there is a change to the uses or disclosures, your rights, and my duties, or other privacy practices stated in this Notice. I will mail updates of my notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. A copy of the current Notice will be available throughout my practice. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the California State Department of Health Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

OTHER USES OF INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide my practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that I am required to retain our records of the care that we provided to you.

PRIVACY OFFICER

I am the privacy officer for my practice. You may contact me with questions or comments by telephone at (415) 409-0944, or by mail to Pacific Coast Psychiatric Associates, 2019 Webster Street, San Francisco, CA 94115.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. You may contact me with questions or comments by telephone at (415) 409-0944, or by mail at Pacific Coast Psychiatric Associates, 2019 Webster Street, San Francisco, CA 94115.

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NOTICE OF OFFICE POLICIES AND PROCEDURES, *EFFECTIVE JANUARY 1, 2010*

PURPOSE OF THIS INFORMATION

In order for me to provide the best care possible, I want my patients to have as much pertinent information as is possible. If you have any questions or concerns about the healthcare or business practices of this office please feel free to discuss them with me.

PRIVACY AND RELEASE OF INFORMATION

Services you receive in this office are confidential, except in the circumstances listed below.

1. Threats of harm to self or others
2. Abuse of a child, vulnerable adult, or developmentally disabled person
3. A court order to release information
4. Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen (14) days.
5. If you will be applying your health insurance benefits, we may be required to provide information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing the Acknowledgement of Receipt of Office Polices and Procedures form you consent to release of that information to your health plan. *Psychotherapy notes are handled separately under HIPAA and have additional protections.*
6. If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment in this office.
7. In some instances, as provided by California law, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

In circumstances other than these, I will not release information about your treatment without your authorization.

EMERGENCY CONTACT

Messages left on voicemail are retrieved regularly and calls are returned as soon as possible. If you need more rapid attention for your own or someone else's safety, do not delay while waiting for me to return your telephone call. *Please call 9-1-1 or report to the nearest hospital emergency room.*

PATIENT RECORDS

An electronic record (file) is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to entities you designate, at your expense, according to charges stipulated by California law. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record.

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You may receive a free copy of your record and a free accounting of non tine disclosure(s) each year. Please contact PCPA to obtain these documents. PCPA will require your request to be in writing:

Pacific Coast Psychiatric Associates
2019 Webster Street
San Francisco, CA 94115

SECURITY PROCEDURES

I make reasonable efforts to prevent access and disclosure to unauthorized personnel. I keep an ongoing log of potential risks and the physical and electronic safeguards implemented to limit these risks. I require my business associates to abide by all applicable privacy regulations.

INSURANCE BENEFITS AND PATIENT RESPONSIBILITY FOR FEES

Only your health insurance plan can describe your benefits to you or verify provider eligibility. My administrative staff will help you obtain this information from your health insurance plan, but you must contact the health insurance plan directly for verification. If charges are denied by a health insurance plan they become entirely your responsibility, even if you had understood from your health insurance plan that the charges would be paid by them.

FEES AND PAYMENT

Payment for charges not covered by your health insurance plan (including co-payment, co-insurance, and deductible amounts) is due in full at the time services are provided unless prior arrangements have been made.

UNPAID BILLS

It is important that you discuss with me any financial hardship that you may have. Doing so may allow us to arrive at a mutually agreeable payment plan that allows the continuation of your treatment. If this cannot be accomplished, seriously delinquent accounts may be referred to a collection agency and we may have to terminate our relationship as provider and patient. Information necessary to effect collection will be released to the collection agent. Should it become necessary to file suit in this context, you agree to pay reasonable attorney fees. A service fee of 1.5% will be charged on balances more than thirty (30) days past due.

LATE CANCELLATIONS AND MISSED APPOINTMENTS

Failure to keep a scheduled appointment will result in a charge for the full fee of the scheduled appointment, unless you cancel at least forty-eight (48) business hours prior to the appointment time.

Please note that insurance health plans do not pay for missed appointments, these charges will be entirely your responsibility.

GRIEVANCE PROCEDURES AND COMPLAINTS

If you have any questions or concerns about administrative or business matters in this office, please discuss them with me.

If you have any questions or concerns about your treatment, you are encouraged to discuss them with me. In addition, or instead, the following avenues are available:

1. You may contact your health insurance plan or behavioral health benefit manager;
2. If you feel the problem is serious and/or you have not reached resolution through one of the avenues above, you can file a complaint with the California State Department of Health Services. Their mailing address is The Department of Health Services, Licensing and Certification, 350 90th Street, 2nd Floor, Daly City, CA and their telephone number is (800) 554-0353.
3. You may also file complaints regarding privacy practices to the Secretary of the U.S. Department of Health and Human Services.

FEES

Fees are ($ 300.00) for the first appointment in an episode of care. Fees for subsequent individual appointments are ($ 225.00) for an appointment of (45)minutes and ($ 175.00) for an appointment of (20) minutes.

These fees are subject to change; however, any changes will be discussed with you. Fees for other services are by arrangement.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations.

I have received a copy of the Notice of Privacy Practices from:

Pacific Coast Psychiatric Associates
2019 Webster Street
San Francisco, CA 94115

Patient Signature: ______________________ **Date:** ______________

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: ______________________ Relationship to Patient: ______________

Signature: ______________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of PCPA's Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

Patient Signature: ______________________ **Date:** ______________

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: ______________________ Relationship to Patient: ______________

Signature: ______________________ Date: ______________

FOR INTERNAL USE ONLY

If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name