PATIENT AGREEMENT

Geriatric Psychiatry Direct
5701 Lonetree Blvd. Ste 323
Rocklin, CA 95765
916-303-4353

Welcome to Geriatric Psychiatry Direct

We are committed to ensuring that every patient receives the highest quality psychiatry services possible. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and ask the office staff if you have any questions.

Membership Fees

In order to provide our patients high quality, personalized and attentive care, patients will be assessed a small monthly membership fee. Your complete satisfaction is important to us, so you will only be assessed the membership fee the month AFTER you establish care as a patient. If you decide not to continue care, this fee will not be collected and only your insurance will be billed for the visit. The amount of the membership fee is subject to change. Membership fees can be paid by electronic debit straight from your checking account or by credit card.

You can cancel your membership at any time. Your membership will be active through the end of the current month, and future months will no longer be billed.

Initial Evaluations

Initial Evaluations involve one 90-minute session. Your provider may request information from your other health care providers before making a diagnosis and/or treatment recommendation.

Follow-Up Sessions

Following the initial evaluation, your provider will discuss his/her assessment with you and make recommendations regarding medication(s) and/or psychotherapy. Your provider may request a blood test or an EKG prior to starting you on a particular medication. If your provider determines medication is appropriate for your treatment, our staff will schedule you for follow-up sessions. In these sessions, your provider will carefully monitor your reaction to the medication(s) prescribed and any side effects. These follow-up sessions typically last 30 – 45 minutes, although they may take somewhat longer in the early stages of treatment.

No Show & Late Cancellation Policy

We reserve your appointment time specifically for you and you alone. For this reason, Geriatric Psychiatry Direct charges a $50 fee for no shows and appointments cancelled with less than two (2) business days' notice.

We also understand that your time and money is valuable. For this reason, our office staff will call to remind you of scheduled appointments. However, it is the responsibility of the patient to keep track of their scheduled appointments.

Regular Attendance

The relationship between a provider and his/her patient is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps ensure that you receive the highest quality care possible.

Late Arrivals

If you arrive late for a scheduled appointment and your provider determines that there is enough time remaining, he/she will see you for the remainder of your appointment time. That said, your provider may also request that you schedule an additional appointment with him/her.

Children and Appointments

We kindly ask that you do not bring your children or grandchildren to your appointments unless they are specifically requested to attend by your provider. Please note that we do not permit children in our waiting area without the supervision of a parent, guardian, or caretaker.

Same Day Appointments

Many insurance companies do not pay for two mental health visits on the same day. If you have visits with your psychiatrist and therapist on the same day, you may have to pay out-of-pocket for one of these visits.

Forms and Documents

Please notify your provider at the beginning of each session if you need certain forms completed. As necessary, medical forms will be completed by your provider while he/she meets with you in your session. If your provider is willing to fill out your forms outside of an appointment time, it may take up to 48 hours for the forms to be completed.

Requests for Disability

Geriatric Psychiatry Direct does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf; however, your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment with him/her for this purpose.

Privacy Practices

A copy of our privacy practices is posted in the office and available at the front desk.

Emergencies and Urgent Consultations

For your benefit, a covering provider will be available each business day after office hours until 8 p.m. and from 9:00 a.m. to 1:00 p.m. over the weekends, to assist you with any urgent issues or problems you are having with medication. To reach the covering provider please call our office at (916) 303-4353 and follow the automated menu. In the event of an emergency, please call 911 or go directly to the emergency room.

Medication

To ensure the best reaction to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, cancelled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication. In general, we will insist that you see your provider before refilling your medication.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I have read and agree to this Patient Agreement in its entirety.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Patient Agreement as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Health Care Surrogate
- ☐ Power of Attorney for Health Care
- ☐ Executor/Administrator

Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

PATIENT CONSENT TO TREATMENT

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Geriatric Psychiatry Direct for diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

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- ☐ Executor/Administrator

Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges incurred for services rendered to me. I understand that my insurance will be billed as a courtesy and that I am responsible for any remaining balance, copayments or charges that are denied due to non-coverage. I understand that medical services and billing will be conducted through Beverly Chang, MD Inc. which I authorize to bill my insurance and accept payment on my behalf for services rendered.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

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- ☐ Executor/Administrator

Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I was offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and available at the reception desk, and a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient Signature _____ Date _____

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