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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 the operation of this office.

APPOINTMENTS

All sessions are by appointment only. Psychotherapy sessions are usually scheduled for 30 to 45 minutes. Medication visits are usually 15 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 fee.

EMERGENCIES

I check my voice mail messages at regular intervals during the business day (Monday through Friday). However, due to the nature of an outpatient practice, I may not receive or be able to respond to your call immediately. If a situation requires an immediate response, please call the emergency back-up number for established patients (510-296-5443) to reach me or the on-call physician, call 911, or go to the nearest hospital emergency room. I do *not* work on the weekends and certain holidays. I do not typically return calls on weekends (Saturday/Sunday).

FEES

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 $750 per 60 minutes for private pay clients (not negotiated with an insurance plan). Longer evaluation sessions are prorated according to the $750/hour rate. After the evaluation, the fees for **follow-up** sessions depend on time spent, level of complexity, and whether or not it is private pay. 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 a rate of $560/hour. Other services such as copying/faxing/mailing medical records may also involve fees. Fees are *subject to change* at any time.

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. *Interest* may be charged on account balances 60 days or more past due at a rate of 10% per month. For billing, please call 650-349-9001 or email at: capp.billing@gmail.com.

CONFIDENTIALITY

Unless you give explicit authorization for release of information, your treatment is strictly confidential—with the following exceptions:

1. If you pose an imminent danger to yourself or others.
2. If you are unable to take care of your basic needs because of mental illness.
3. In cases of suspected child abuse.
4. Under certain circumstances when ordered by a court.
5. With the authorization you give at the time of registration, some treatment information such as name, diagnosis, date and type of service, and charge is routinely given to insurance or managed care companies to facilitate reimbursement. If your company requests further information, I will discuss the request with you prior to releasing any information.

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 I understand and agree to the above.

Guarantor signature:_____

Printed Name:_____ **Date**:_____