DEREK OTT, M.D., INC

ADULT, ADOLESCENT & CHILD PSYCHIATRY

10850 WILSHIRE BLVD, SUITE 200, LOS ANGELES, CA 90024 PH (310) 470-2033/ FAX (310) 475-2936

PATIENT INFORMATION

NAME (PATIENT) *DATE OF BIRTH*

_____ ____/____/____

ADDRESS *STREET* *CITY* *STATE* *ZIP*

_____

HOME PHONE *WORK/CELL PHONE* *EMAIL* (SEE POLICY)*

_____ _____ _____

MOTHER/ FATHER *BIOLOGICAL/STEP/FOSTER/ADOPTIVE* **FATHER/ MOTHER** *BIOLOGICAL/STEP/FOSTER/ADOPTIVE*

_____ _____

ADDRESS OF PARENT (IF DIFFERENT THAN ABOVE) *MOTHER/FATHER*

STREET *CITY* *STATE* *ZIP* *PHONE*

_____

1. I CONSENT TO/AUTHORIZE SERVICES OF DEREK OTT, M.D., WHICH MAY INCLUDE MEDICATION THERAPY, PSYCHOTHERAPY, LABORATORY TESTS, DIAGNOSTIC PROCEDURES, AND OTHER APPROPRIATE THERAPIES.

2. FEES: WE HAVE AGREED UPON A FEE OF $400_____PER 50 MINUTE SESSION, $250_____PER MEDICATION MANAGEMENT SESSION (15-30MIN), AND $800 ____PER EVALUATION. VISITS TO SCHOOLS (OR OTHER SITES), TESTIFYING IN COURT/IEP'S AND OTHER SERVICES WILL BE BILLED AT A RATE OF $400 PER HOUR AND WILL INCLUDE TRAVEL TIME ____. I AGREE TO PAY IN-FULL AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE _____. THE FEE FOR RETURN CHECKS IS $35_____.

3. REPORTS: ALTHOUGH SUMMARY REPORTS OF THE EVALUATION WILL BE MADE AVAILABLE ON REQUEST, MORE EXTENSIVE REPORTS WILL BE CHARGED BASED UPON THE SAME HOURLY RATE ($400 PER HOUR)_____.

4. MISSED APPTS: I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AT THE FULL RATE AND FOR CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE, UNLESS THERE ARE SPECIAL CIRCUMSTANCES AGREED UPON IN ADVANCE .

5. INSURANCE: IF I CARRY HEALTH INSURANCE COVERING ANY SERVICE THAT DR. OTT OFFERS, IT IS MY RESPONSIBILITY TO CAREFULLY REVIEW MY INSURANCE COVERAGE PRIOR TO MY VISIT. INSURANCE BENEFITS ARE A MATTER BETWEEN ME AND MY INSURANCE COMPANY. DR. OTT DOES NOT BILL INSURANCE DIRECTLY_____.

6. TELEPHONE: TELEPHONE CONTACTS ARE A ROUTINE AND EXPECTED PART OF MEDICAL CARE. BRIEF, ROUTINE QUESTIONS AND MEDICATION REFILLS WILL BE HANDLED MONDAY THROUGH FRIDAY FROM 9AM TO 5PM. TELEPHONE CONTACT LONGER THAN 15 MINUTES WILL BE CHARGED ON A PRORATED BASIS OF THE USUAL FEE. A SIMILAR ARRANGEMENT WILL APPLY TO CALLS FOR PRIOR AUTHORIZATION FOR MEDICATION_____.

7. *EMAIL: I WILL NOT USE EMAIL FOR COMPLICATED MEDICAL QUESTIONS THAT SHOULD PROPERLY BE ADDRESSED VIA A CONSULTATION (NOT SUITABLE FOR ANY SORT OF EMERGENCY COMMUNICATION). I AM AWARE THAT MY EMAIL COMMUNICATION WITH DR. OTT WILL BECOME PART OF MY MEDICAL RECORD. I NOTE THAT EMAIL SYSTEMS MAY BE INSECURE/UNPROTECTED. HOWEVER, BY MY CONTINUED COMMUNICATION VIA EMAIL WITH DR. OTT, I AM ACCEPTING THE INHERENT INSECURITY AND THE PRIVACY RISKS THEREIN. I WILL BE SURE TO INCLUDE MY FULL NAME IN ALL COMMUNICATION_____.

8. RELEASE: I HEREBY AUTHORIZE THE RELEASE OF LIMITED INFORMATION TO MY INSURANCE COMPANY AS REQUIRED FOR BILLING.

9. CONFIDENTIALITY: ANY INFORMATION I DISCLOSE WILL BE MAINTAINED IN THE STRICTEST CONFIDENCE, UNLESS I SPECIFICALLY AUTHORIZE ITS RELEASE, OR LAW OR PROFESSIONAL STANDARDS OF PRACTICE REQUIRE ITS RELEASE. IN PARTICULAR, MY RIGHT TO CONFIDENTIALITY MAY NOT BE MAINTAINED IF I AM IN IMMEDIATE DANGER TO MYSELF OR TO SOMEONE ELSE, AND STEPS MUST BE TAKEN TO ASSURE MY OR ANOTHER'S SAFETY. ALSO, ANY CLINICIAN HEARING FROM A PATIENT THAT A CHILD OR ELDER IS BEING OR HAS BEEN PHYSICALLY OR PSYCHOLOGICALLY ABUSED IS REQUIRED BY LAW TO REPORT THIS INFORMATION TO A DESIGNATED AGENCY. IF IT IS NECESSARY TO DISCLOSE SOME INFORMATION I HAVE PROVIDED TO ANYONE ELSE, THIS WILL BE DISCUSSED WITH ME.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AGREE TO THE ABOVE TERMS.

_____ _____

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY DATE