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:	*Last*	*First*	*Middle*		*Date of Birth* / /
Address:	*Street*	*City*	*State*	*Zip*	
	Home Phone	*Cell/other Phone*			*Email*(see policy)*

IN CASE OF EMERGENCY CONTACT

Name:	*Last*	*First*	*Relation*	*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. We have agreed upon a **fee** of **$450**_____per 50 minute session, **$275**______per medication management session (15-30min), and **$900**____per evaluation. Visits to schools (or other sites), testifying in court/IEP's and other services will be billed at a rate of $450 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. Although **summary reports** of the evaluation will be made available on request, more extensive reports will be charged based upon the same hourly rate ($450 per hour)_____.
4. 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. If you carry health **insurance** covering any service that I offer, it is your responsibility to carefully review your insurance coverage prior to your visit. Insurance benefits are a matter between **<u>you</u>** and **<u>your</u>** insurance company. I do **NOT** bill insurance directly_____.
6. **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 contacts 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** communication with Dr. Ott is provided as a convenience to the patient. Please do not use email for complicated medical questions that should properly be addressed via a consultation (not suitable for any sort of emergency communication). Please be aware that your email communication with Dr. Ott will become part of your medical record. Please note that email systems may be insecure/unprotected. However, by your continued communication via email with Dr. Ott, you are accepting the inherent insecurity and the privacy risks therein. Please be sure to include your full name in all communication_____.
8. I hereby authorize the release of limited information to my insurance company as required for billing.
9. Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or law or professional standards of practice require its release. In particular, your right to **confidentiality** may not be maintained if you are in immediate danger to yourself or to someone else, and steps must be taken to assure your 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 you have provided to anyone else, this will be discussed with you.

I certify that the above information is correct to the best of my knowledge and agree to the above terms.

____________________	________________________	_______________
Patients Signature	Insured, Guardian or Responsible Party	Date