

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

CELL / WORK 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. **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 **\$450** PER 50 MINUTE SESSION (30-50min), **\$275** PER MEDICATION MANAGEMENT SESSION (1-30MIN), 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. **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 (\$450 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.
10. "THE **OPEN PAYMENTS DATABASE** IS A FEDERAL TOOL USED TO SEARCH PAYMENTS MADE BY DRUG AND DEVICE COMPANIES TO PHYSICIANS AND TEACHING HOSPITALS. IT CAN BE FOUND AT [HTTPS://OPENPAYMENTSDATA.CMS.GOV.](https://openpaymentsdata.cms.gov)"

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

INFO/CONTRACT-01/01/2023