Susan A. Harris, MD

PSYCHIATRY & PSYCHOPHARMACOLOGY

OFFICE POLICY & PRIVACY STATEMENT

- A 48-hour cancellation notice is required for each appointment. Otherwise, you will need to pay for the missed appointment at your next visit.
- Fees are to be collected at the time of each appointment.
- Forms of payment accepted are cash and personal check.
- At the end of each visit, you will be given a receipt for services rendered. You can submit these receipts to your insurance company for reimbursement.
- Generally, office visits for **medication management** are once a month. However, they may occur sooner when a new medication is initiated, when a change in medication is taking place, etc.
- Office visits for **medication management** are 25 minutes in length with an **initial evaluation** of about 55 minutes. The **initial evaluation** is $250.00, and each **office visit** thereafter is $125.00.
- Office visits for **therapy** are usually held 55 minutes for each session. Each therapy session is $220.00. The **initial evaluation** for therapy is 75 minutes at $295.00.
- I am willing to combine **medication management** visits with **therapy** at $220 per visit, at a length of 55 minutes.
- **Privacy disclosure consistent with HIPAA and California law.**
  Everything that is discussed at each appointment will be kept private and confidential unless you give your written consent to do otherwise. You may revoke this consent at any time.
  Exceptions are as follows:

  (1) If you state or it is obviously evident that you are in imminent danger of harming yourself

  (2) If you state you are going to harm someone else

  (3) If there is suspected abuse or neglect of an elder, dependent-adult, or child

  (4) If you are too ill to care for yourself and there is no one able to care for you

  (5) If your information is subpoenaed by a court of law. For this, I will ask you to sign a consent form as well, making sure you are aware of the situation.

  Other information (e.g., diagnoses, name, or date of birth) **may be necessary to disclose** to a pharmacist dispensing medication, a laboratory performing tests, or the health insurance agency to which you submit your receipts for services rendered. Your information may also be disclosed to enable oversight agencies to oversee the originator of the psychotherapy notes and other information.

Patient's Initials Here _____ *(1 of 2)*

- **Telephone calls:** There is no charge for necessary calls -- that is, calls about side effects, the presence of severe symptoms, lost medication, or the need for a change in treatment, although I may need to see you face to face before I can respond. The time required for all other calls is charged to patients at my regular, non-discounted fee (please ask).
- **For refills of medications: *Please call your pharmacy***. They will contact me with your request. If for some reason there is a problem with your request, either the pharmacy or I will get back to you. Please note that during the weekend, I may not be able to get back to the pharmacy until the following week. If you have any questions about the above information, please discuss this with me. *Please do not wait until you are completely out of medication before contacting the pharmacy.*
- **Reports**: The time required to compose disability and other reports is charged to patients at my regular, non-discounted fee (please ask), unless they are paid for by the party requesting the report or can be done during a clinical session. **I decline to do reports for legal purposes, such as establishing ground for a personal injury claim.**
- **Sharing your record with any other Doctor or Therapist:** If you would like me to do so, please ask me for a consent form and fill the information required.
- **You have a right to inspect and copy your health information**, with limited exceptions. You must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. I can deny your request if I believe providing you with the information you are requesting is likely to cause substantial harm to you. You may appeal my decision and you have a right to request that your information be transferred to another mental health professional.
- **You have a right to amend or supplement your health information** if you believe it to be incorrect or incomplete. Your must make your request in writing, and include the reasons why you believe the information is inaccurate or incomplete. I am not required to change you health information, however, especially if I do not have the information, if I did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you do not be permitted the party who created the information to inspect a copy the information at issue, or if the information is accurate and complete as is. If I do refuse, I will provide you with information about why I am denying your request. You also have a right to request that I add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
- **Verification of Identity**: It is the policy of this practice that the identity of all persons who request access to protected health information be verified before such access is granted.
- **Complaints**: Complaints regarding the **Notice of Privacy Practices** of how this office handles health information should be directed to the Privacy Official, which is myself.

Thank you for your interest in me as a possible mental health provider.

I, _____, understand and agree to the above stated conditions.
(PATIENT'S PRINTED NAME)

Signed, _____ Dated _____ / _____ / _____

Susan A. Harris, MD ♦ 550 Hamilton Avenue, Suite 140, Palo Alto, CA 94303 ♦ PH: 650.776.8787 ♦ FAX: 650.838.0856