David Kan, M.D.
ADDICTION, FORENSIC & GENERAL PSYCHIATRY

1846 Tice Valley Blvd
Walnut Creek, CA 94595
Tel 925-953-2833
www.davidkanmd.com

CONSENT FOR TREATMENT

Welcome to our practice. This information sheet covers a number of important issues related to your treatment. Please read it and acknowledge receipt by signing the intake form.

CONFIDENTIALITY

Our practice safely stores your protected health information. Our electronic charting and email system are securely encrypted to maintain your confidentiality.

Our providers must have your permission before revealing any information about you, with the following exceptions:

1. **Legal limitations** – We are obligated by law to disclose information under certain legally defined situations; (1) if you are an imminent danger to yourself or others; (2) if you tell us about an incident of child abuse by you or someone else; (3) if you tell us about an incident of abuse of someone over age 65 or a disabled adult; (4) if you are unable to provide food, clothing or shelter for yourself; (5) if the court orders a release of information.
2. **Insurance companies** – If Dr. Kan is contracted with your insurance panel or you submit invoices to your insurance company, be aware that the company may request certain information from us as a requirement of your reimbursement. This information could include dates of appointments, diagnoses, medications prescribed, and treatment summaries.
3. **Communications with others** – In order to provide you with excellent medical care, we may ask for consent to talk with your primary care provider. We keep an emergency contact on record to be used only in the case of an emergency.

PROVIDER AVAILABILITY

1. **Phone calls** – Our staff is available during work hours to answer your calls and emails to help with scheduling or billing questions. If you prefer more privacy, you may leave a message on your Dr. Kan's voicemail or email that will be returned as soon as possible.

   We do not charge for phone calls lasting less than five minutes. Longer calls are prorated.

   Please keep in mind that insurance companies do not cover phone calls and patients are responsible for those charges. In order to provide you with excellent care, your physician may make collateral phone calls to your other providers.

2. **After hours phone calls** – Our providers can be reached after hours through our voicemail system. If you are having a clinically urgent situation on an evening, weekend or holiday, you can contact Dr. Kan. If you are having a medical or

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psychiatric emergency, do not wait for a call back but instead call 911 or go to your nearest emergency room.

3. **Email** – My practice is maintains patient confidentiality and I encrypt your protected health information. When you receive an encrypted email from Dr. Kan, you will be asked to create a password and sign in. Please keep in mind that emails you send through your server may not be secure.

4. **Texting** – Texting is not a secure form of communication. Our providers do not return text messages but instead will respond by secure email.

5. **Refill requests** – Please allow two days for refill orders to be sent in. We are not allowed to authorize refills if you do not have a future appointment scheduled.

SCHEDULING

1. **Length of sessions** – Intake consultations are 60 minutes, psychotherapy sessions are 45 minutes, and medication management appointments are 25 minutes. Our providers start and end sessions on time.
2. **Appointment reminders** – Our office sends email and phone message reminders three days prior to your scheduled appointment. If you receive an appointment reminder in error, please call or email the office to clarify or cancel.
3. **Missed appointments** – We ask for a 48-hour notice for any cancellations. This policy is for business hours. For example, if your appointment is on a Monday we request notice by Thursday. *Be aware that insurance companies do not cover missed sessions and you will be charged the full cash fee for the appointment.*
4. **Holidays and vacations** – Dr. Kan observes holidays and our clinicians take about three weeks of vacation each year.

BILLING

1. **Payment** – Payment is collected at the time of service by cash, credit card, or check made out to David Kan, M.D. For your convenience, we keep a current credit card on file for all patients. This information will be stored securely in your chart.
2. **Insurance billing** – Dr. Kan is an out-of-network provider with all insurance companies. Payment in full is required at each appointment. Our office is happy to assist you with getting reimbursement from your insurer for any out-of-network benefits you have. If your insurer allows electronic claims, our office will submit the claim on your behalf. If your insurer does not allow electronic claims for patient reimbursement, then we will provide you with the documentation you need to submit the claim yourself.
3. **Medicare** – For administrative and legal reasons, we have opted out of Medicare. If you are eligible for Medicare, please sign an agreement with Dr. Kan stating that you will not submit invoices to Medicare.
4. **Statements** – If you are paying out of pocket for your visits, statements are

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mailed upon request. You are welcome to request documentation of payment at any time.

2015 FEE SCHEDULE

- General Adult Psychiatry Fees – For adults 20 years old and up
- Initial assessment, 60 minutes, $425
- Buprenorphine/Suboxone Induction, 90-120+ minutes, $800
- Individual psychotherapy, 45 minutes, $275
- Couples or Family therapy, 45 minutes, $275
- Medication Management appointment, 25 minutes, $225
- Email consult, $75
- Extended (over 5 minutes) phone contact, $5 per minute
- Document preparation for a third party, Varies (attorney, employer, etc.)
- Medical records handling/copying, $30 plus $1.15 per page for first 30 pages, $0.90/page thereafter
- Fee for NSF (bounced) check, $35
- Between-visit prescription refill, $25
- Urgent prescription refill, $35
- Appointment Missed, or Canceled, Full Appointment Fee without 48 hours notice

Fees are increased by approximately 3% a year starting on January 1st.
Please keep a copy of this for your records and sign the intake form to acknowledge receipt of this consent.

We look forward to working with you.

_____ _____
Patient Signature Date

_____
Patient Name Printed