Christine Chiu, MD
Psychiatrist

2660 Solace Place Suite D1
Mountain View, CA 94040
(650) 335-5406

Consent For Treatment

I, _____ (client name), understand that:

1. I am willfully entering into a professional relationship with Dr. Christine Chiu. I hereby authorize treatment by Dr. Chiu and assume financial responsibility for treatment. The nature and frequency of visits will be agreed upon by Dr. Chiu and me.

2. There is an expectation that treatment will benefit me, but there is not a guarantee that it will. In order to achieve desired result, this type of treatment requires significant and active effort on my behalf.

3. There are certain risks associated with psychiatric treatment, such as being emotionally uncomfortable, facing difficult aspects of my life, or experiencing unwanted effects of medication.

4. Outside our sessions, I will communicate with Dr. Chiu by telephone primarily. I will not be charged for necessary calls (emergency, severe symptoms or side effects, lost medications, rescheduling) lasting less than 5 minutes. I will reserve more detailed discussions about my treatment to my appointment times.

5. If I do not cancel my appointment with a 48-business-hour notice, I will be charged the full appointment fee. For example, if my appointment is on a Monday, I will notify Dr. Chiu by the previous Thursday.

6. When I call Dr. Chiu, I will likely reach her confidential voicemail, as she usually does not answer the phone during sessions. I agree to call 911 or go to the emergency room if I have a life-threatening emergency, as there will likely be some delay before Dr. Chiu receives my message or is able to respond to me.

7. I agree to pay for services by cash, check or major credit card at the time of treatment. I understand there is a $50 fee for returned checks. Non-payment of fees may be grounds for suspension of services by Dr. Chiu. Services may be resumed when the past due balance is paid.

8. **Insurance**:
    a. Dr. Chiu is a contracted provider with Anthem Blue Cross, Cigna, Stanford Cardinal Care (MHN). I am responsible for calling my insurance company to verify my benefits before my initial appointment and to keep up with my latest benefits and coverage as these change often. I agree to keep my insurance information up to date with Dr. Chiu at all times.

b. If Dr. Chiu is not on my insurance panel, I am responsible for submitting my own claims and collecting reimbursement from my insurance provider. I understand that reimbursement from my insurance is not guaranteed. Dr. Chiu may provide me with a monthly bill statement that I can submit to my insurance (except Medicare).

c. Dr. Chiu is not a Medicare/Medigap provider and will not bill Medicare on my behalf, even if I am Medicare beneficiary. In addition, I agree not to submit claims to Medicare for reimbursement of Dr. Chiu's services.

9. Dr. Chiu will provide sufficient refills until next session during the appointment. If I need a refill I will call my pharmacy and have them contact Dr. Chiu for authorization at least 3 days prior to running out. Refills will only be approved if I have a scheduled appointment.

10. Substantial out-of-session work on my behalf like non-urgent or frequent phone calls, report preparations, and consultations may be charged according to the hourly rate. Dr. Chiu will inform me if any out-of-session work will be billed. Dr. Chiu does not provide reports for legal purposes (personal injury, permanent disability claims).

Schedule of Fees

Medication Management	25 minutes	$230
Psychotherapy and/or Medication Management	55 minutes	$350
Comprehensive Evaluation	75 minutes	$450

The above fees are subject to future change. I will be notified in advance of any such changes. By signing below, I acknowledge that I have read and understand the above contract, and I agree to be bound by all of its terms without exception.

_____ _____

Signature of Client Date

_____

Printed Name of Client

_____

Signature of Dr. Christine Chiu