Fulton Psychological Group

Steven Sager, M.D.

Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them during our meeting. Once you sign this, it will constitute a binding agreement between us.

Meetings and Professional Fees

The Initial psychiatric diagnostic interview requires a 90 minute evaluation. The follow up visits are typically monthly 30 minute appointments, but frequency can fluctuate depending on the client's need. Follow-up appointments that involve psychotherapy and medications are usually 45-50 minutes and may be seen 1-4 times per month. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. In addition, if you fail to come to a scheduled appointment, you will be expected to pay my hourly fee in full. My hourly fee is $400 (please see fee schedule). You will be expected to pay for each session at the time it is held. Visit expenses are your responsibility regardless of insurance coverage. I am not on any insurance panels and do not bill insurance. If you would like an insurance invoice, it can be provided to you via e-mail or mail at the end of each month. No information will be provided directly to your insurance company. In addition to scheduled appointments, it is my practice to charge my fee on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 10 minutes, attendance at meetings or consultation with other professionals which you have authorized, preparations of records or treatment summaries, or the time required to perform any other service which you may request of me. If you require an emergency prescription or it has run out prior to our scheduled meeting and I need to call it in, there is a fee. If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. In the event of non-payment, a collection agency or small claims court may be utilized, and you will be responsible for reasonable collection fees. In most cases, the only information which I release about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

Fee schedule:

Service	Time	Fee
Office Evaluation (New Client)	90 min (75 min visit/15 min documentation)	$600
Psychotherapy + medication	60 min (50 min visit/10 min documentation)	$400
Expanded med follow-up	30 min (25 min visit/ 5min documentation)	$200
911 Phone Session	0-15 min	$130
911 Phone Session	16-30	$200
Emergency Prescription & Beyond 90 day check-in		$ 90
Medical Records Requests		$ 90

Fee schedule is subject to change each year on Jan 1st.

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Contacting Me

I am often not immediately available by telephone. Currently, I am in the office three days a week. I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail which I check during these hours or by the patient care manager. I will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you communicate with me via email, please understand the risks associated with using email, such as: email can be intercepted, altered, forwarded, or used without authorization or detection, email can be used as evidence in court, email may be read by my office staff and email may not be secure and the confidentiality of such communication may be breached by a third part. Thus, you should not use email for communication regarding sensitive therapeutic information or regarding matters that need a more immediate response. If you are difficult to reach, please leave times when you will be available. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call your family physician or 911. **If you are feeling suicidal or a family member is threatening violence or suicide, you need to call 911**. The police are well trained to handle situations ranging from suicidal individuals to out-of-control teens. Additional numbers that may be helpful include: California Youth Crises Line (800) 843-5200, Child Abuse Hotline (800) 540-4000, Domestic Violence Hotline (323) 681-2626, Elder Abuse Hotline (800) 992-1660 and Suicide Prevention Center (310) 391-1253. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

Confidentiality

Within certain limits, information revealed by you during evaluation and treatment will be kept strictly confidential and will not be revealed to any person or agency without your written permission. Because I work within a group practice, consultation may occur with professionals within this practice. In addition, billing information may be accessed by administrative assistants and/or accountants. Tape recording of any part of the treatment sessions may not occur without your written permission. There are certain situations in which, as a psychiatrist, I am required by law to reveal information obtained during treatment to other persons or agencies. These situations are as follows: 1) if you are a threat of grave bodily harm or death to yourself or another person, 2) if I become aware of a situation of neglect or harm of a minor, 3) if a court of law issues a legitimate subpoena, 4) if I become aware that an elderly person is being physically harmed, and/or 5) you are a court-referred client. If I believe there is risk of you harming someone else or self-inflicting harm, I am not mandated, but have an ethical responsibility to give this information to appropriate persons in order to obtain the best care for you or those you may harm. These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action. Although the parent of a minor is the "holder of privilege," disclosing the content of sessions with minors to parents tends to undermine treatment. Reporting to parents is kept to general progress/issues or if the minor is involved in dangerous or harmful activities.

Your signature acknowledges that you have read and understand the above explanations regarding informed consent, confidentiality, and patient responsibilities.

Patient's Name: ______________________________ Date: ____________

Signature (parent's if patient is a minor): ______________________________

Fulton Psychological Group

CHILD INFORMATION

Name of Child:______________________________ Date:____________

Home Address:____
Street City Zip Code

Birth Date:________________ School:______________________

Grade:___________________ Teacher:_____________________

Name of Parent:_____________________ Occupation:_______________

Home Address: ____

Home Phone #:__________________ Work Phone #:__________________

Cell Phone #:__________________ E-mail:______________________

Name of Parent:_____________________ Occupation:_______________

Home Address: ____

Home Phone #:__________________ Work Phone #:__________________

Cell Phone #:__________________ E-mail:______________________

Child's Previous Therapy:_____________________________________
Therapist's Name Period of Time Therapy Issue

Physician:_______________________ Phone #:______________________

Please describe your living arrangements:

_________________________ _____________________________
Name Age Relationship Name Age Relationship

_________________________ _____________________________
Name Age Relationship Name Age Relationship

In case of emergency notify:___________________ Phone #:_______________

If you would like an invoice provided to you for insurance purposes, please provide the e-mail address where you can receive invoices ____________________________________.

Who referred you to my practice?_____________________________________
It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person.** No other information will be disclosed.

Signature:______________________________ Date:_______________

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Why are you seeking therapy for your child at this time? ______________________

____

____

Check any symptoms your child has exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Difficulty Sleeping in Own Bed
___ Very Active
___ Easily Distracted
___ Has Conflicts with Peers
___ Doesn't Follow Directions
___ Other (please describe): ______________________________________

List and describe any history of emotional disorder(s) in your child's biological family:

____

____

List and describe any significant life events (e.g. divorce, death in family, etc.): ________

____

How does your child function at school (i.e. grades, with peers with teachers)?

____

____

List and describe your child's current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, etc.): ______________________________________

____

List any medication(s) and dosage your child is currently prescribed: ________________

____

What are your child's strengths and hobbies? ______________________________

____

Fulton Psychological Group

Recurring ACH Payment Authorization

I authorize regularly scheduled charges to my checking/savings account. I will be charged at the time of service or at the end of our invoicing cycle (i.e. On the 15th or the end of the month). . If the service falls on a weekend or holiday, I understand that the payments may be executed on the next business day. The payment will be reflected on your invoice and the charge will appear on your bank statement as an "ACH Debit". I understand that no prior-notification will be provided unless the amount changes. In which case, you will receive notice from us at least 10 days prior to the payment being collected. I hereby authorize Fulton Psychological Group (FPG) to originate debit and/or credit entries via the Automated Clearing House to the account indicated at the Depository Financial Institution named below, to accept and to debit/credit the amount of such entries to the account. The amount charged is indicated on the consent form.

Account Name:	
Bank Name:	

Bank Routing Number:	
Bank Account Number:	

Routing Number Account Number

I understand this authorization will remain in effect until I cancel it in writing. I agree to notify FPG in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing dates In the case of an ACH transaction being rejected for Non-Sufficient Funds (NSF) I understand FPG may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE:______________________________ DATE: ______________

(Account Holder's Signature)

Patient's Name: ______________________________ Dr.'s Name: ______________

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Fulton Psychological Group

Steven Sager, M.D.

To my patients,

Due to the new privacy laws, we are required to ask you for clarification about our calls to your home, office or cell phone regarding things like appointments, test results, medication side effects and prescriptions. Please answer these questions and sign and date this form. If this information should at any time need to be modified, please call us and we will be happy to assist you.

1) WITH WHOM MAY WE SHARE MEDICAL INFORMATION?

__________ MYSELF ONLY

__________ SPOUSE OR SIGNIFICANT OTHER

__________ PARENT OR LEGAL GUARDIAN

__________ OTHER

____
(First and Last Name of above person)

2) WHERE AND WITH WHOM MAY WE LEAVE A MESSAGE FOR YOU?

HOME: ____

WORK: ____

CELL: ____

OTHER: ____

SIGNATURE: __________________________ DATE: __________

PATIENT NAME: ____________________________________

Telemental Health Informed Consent

I, ____, hereby consent to participate in telemental health with,

____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at______________________ to discuss since we may have to re-schedule.

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7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: ____

and my emergency contact person's name, address, phone: ___________________________

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

______________________________ ____________

Signature of client/parent/legal guardian Date

______________________________ ____________

Signature of therapist Date

The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. ***Nothing reported herein should be used as a substitute for the advice of competent counsel.***

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Fulton Psychological Group

PATIENT EMAIL CONSENT FORM

Patient Name: ______________________ Date: ______ Email: ______________________

Responsible Party Email (if patient is a minor): ______________________

1. Risk of Using Email

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) Email can be forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and online services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Email may not be secure, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions For the Use of Email: Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.**
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) **All email will usually be printed and filed in the patient's medical record.**
d) Office staff may receive and read your email messages.
e) Provider will not forward patient identifiable emails to other healthcare providers without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information.
g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. Instructions: To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the provider.
f) Take precautions to preserve the confidentiality of email.

4. Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined. If I have any questions I may inquire with Dr. Sager or staff.

Fulton Psychological Group

Steven Sager, M.D.

MEDICATION POLICY

Dear Patient:
In order to effectively manage your medication, please be aware that the following guidelines need to be followed:

1. In order to receive refills of your medications, you are responsible to make an appointment to see me **in person** at least once every 3 months.

2. My adult patients are responsible for getting blood work done once a year. I can order this for you, or you may have your primary physician order it.

3. It is your responsibility to notify me immediately of **any** side effects of your medication.

4. I will need to be advised immediately any time another physician starts you on a new medication, or there is a change in your health status.

Patient Name Date

Signature of Patient or Responsible Party (if patient is a Minor)

Date

Fulton Psychological Group

Authorization to Release Information

Patient: ____Date of Birth:____________________

Address:____

I hereby authorize Steven Sager, M.D.. to disclose and/or receive from

____

(name) (phone #) **(fax)**

information pertaining to my (or my child's) psychiatric services rendered from:

________ to ________.

Specific information requested includes: ____

____

This authorization is good until: _________________________________

This authorization allows Dr. Sager to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: ____ Date: ___________
(parent, if patient is a minor)

Dr. Sagers' signature: ____ Date: ___________

FAX: 818. 591-3041

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Consent for Medication (Child)

Child's Name: ______________________________ Date of Birth: ______

I hereby give consent for my child to be treated with ________________________
Medication(s)

Dr. Sager has informed me that the medication my child will be taking will be from the medication groups checked below:

______ Antipsychotic medications ______ Anxiolytic medications
______ Mood Stabilizers ______ Antidepressant medications
______ Stimulants ______ Other

Dr. Sager has discussed with me the following information for each medication my child is to take.

1. The nature of my child's emotional and/or psychiatric condition.

2. The reason for taking medication, including the likelihood of my child improving or not improving with or without such medication.

3. Other reasonable alternatives, if any, are known to be of help in treating problems such as those of my child.

4. The dosage, timing method of administration and probable duration of treatment.

5. The common side effects and possible additional side effects, (including the risk of Tardive Dyskensia if my child is taking antipsychotic medication).

6. I understand that I have the right to accept, refuse, or discontinue medication treatment for my child by telling the doctor at the time.

7. I understand that in agreeing to have my child take medication, I have not eliminated his/her being involved in other forms of treatment.

8. I understand that prior to starting medication; my child should have a complete physical examination, including laboratory testing, and EKG, if recommended by the doctor.

Parent/Guardian Signature: ______________________________ Date: ________
Psychiatrist's Signature: ______________________________ Date: ________