Michelle Kwok M.D.
Adult Psychiatrist
1510 Fashion Island Blvd., Suite 110
San Mateo, CA 94404

Consent to Treatment and Financial Agreement

Name of Patient:___________________Date of birth:______________________

Name of Parent/Guardian if *Pt Under 18:*________________________________

Telephone:_______________________Address____________________________

In applying for services with Dr. Kwok, I understand that I may be administered diagnostic and treatment procedures as may be determined by Dr. Kwok and as approved by myself, the parent or guardian.

Medical and other records may be maintained by Dr. Kwok for assessment and treatment. These records are confidential and are for the use of Dr. Kwok only.

I have read and understand the statements regarding HIPPA and patient's rights.

I understand that medical doctors are licensed and regulated by the Medical Board of California, www.mbc.ca.gov, (800) 633-2322

Dr. Kwok will attempt to safeguard the patients in her care but she will not be responsible for any accidental injuries and assumes no liability for injuries occurring without any fault or negligence.

Dr. Kwok accepts a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of Dr. Kwok he or she is not able to benefit, withdrawal will be recommended and other plans discussed.

I understand that while Dr. Kwok provides her email for potential patients to contact for the sole purpose of scheduling initial appointments; email sent over the Internet is not secure and should not be used to communicate confidential and/or health information directly. It may be accessed and viewed by other users without your knowledge while in transit and thus, its confidentiality cannot be guaranteed. If an email is sent from a patient with sensitive patient information, the patient will bear sole responsibility for any privacy related outcome of this communication, whether intended or not. Dr. Kwok will use an encryption service for e mail communications to her patients.

I understand that while Dr. Kwok will provide information required to obtain insurance company reimbursement, she will not bill insurance companies directly, nor will she negotiate a settlement on disputed charges. I understand that I am fully and personally responsible for payment of Dr. Kwok's charges at time of services rendered. Failure to comply with this policy may result in postponement or cancellation of future visits. Furthermore, if the amount due is not paid in full, I agree to bear all collection costs, court costs and legal fees.

I understand that because of the highly specialized nature of her practice, Dr. Kwok does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, workers compensation cases or victims witness cases. Dr. Kwok is not a Medicare provider.

I understand that Dr. Kwok requests payment at the time of visit.

I understand that as a courtesy to the physician, if for any reason an appointment must be cancelled by the patient, 48 hours notification by telephone will be given to the physician's office (two working days; weekend days and holidays do not count). Failure to properly notify the physician will result in charges at the usual rate for that appointment. Exceptions will be made for emergencies. Such charges are not reimbursed by insurance programs.

I understand that the doctor may charge for telephone consultations and for all other uses of her time on my behalf, at the rate $200/hr.

I have read and understand the above mentioned policies and guidelines and will abide by these for services.

______________________ ____________________________________

Date Signature of Patient/Parent/Guardian