Dan R. Tzuang, M.D.
ABPN Double Board Certified
Child, Adolescent, and Adult Psychiatrist
1101 Dove Street, Suite 155
Newport Beach, CA 92660
Phone (949) 478-4826
Fax (949) 954-7757

Consent to Treatment and Financial Agreement

Name of Patient:_____ Age/Date of birth:_____

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

Email for Patient vs Parent/Guardian if *Pt Under 18*: _____

Telephone:_____ Address_____

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

Medical and other records may be maintained by Dr. Tzuang for assessment and treatment. These records are confidential and are for the use of Dr. Tzuang 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. Tzuang will attempt to safeguard the patients in his care but he will not be responsible for any accidental injuries and assumes no liability for injuries occurring without any fault or negligence.

Dr. Tzuang 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. Tzuang he or she is not able to benefit, withdrawal will be recommended and other plans discussed.

I understand that while Dr. Tzuang provides his email for patients to contact him for the purposes of scheduling appointments and general communication; however, in signing the consent, you are acknowledging that email sent over the Internet is not secure and should not be used to communicate very 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.

I understand that while Dr. Tzuang will provide information required to obtain insurance company reimbursement, he will not bill insurance companies directly, nor will he negotiate a settlement on disputed charges. I understand that I am fully and personally responsible for payment of Dr. Tzuang'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 his practice, Dr. Tzuang does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, workers compensation cases or victims witness cases. Dr. Tzuang is not a Medicare provider.

I understand that Dr. Tzuang requests PAYMENT AT TIME OF VISIT BY CASH/CHECK/CREDIT CARD.

I understand that IF FOR ANY REASON AN APPOINTMENT NEEDS TO BE CHANGED OR CANCELLED BY THE PATIENT, 48 HOURS NOTIFICATION BY TELEPHONE OR EMAIL WILL BE GIVEN TO THE DOCTOR. Failure to properly notify the physician will result in charges at the usual rate for that appointment. Exceptions will be made for legitimate emergencies as per physician discretion. I am in complete agreement that remembering upcoming appointments as set forth by Dr. Tzuang is my sole responsibility, and that Dr. Tzuang is not obligated to send reminder emails/phone calls prior to upcoming appointments as reminders. If you miss a scheduled appointment, you will be charged the full fee for the scheduled visit.

I understand that the doctor may charge (at his discretion, which will be defined depending on situation) for telephone consultations and for all other uses of his time on my behalf, at the rate $175/25 min or $275/hr.

I have read and understand the above mentioned policies and guidelines and will abide by ALL OF THESE POLICIES for services.

_____ _____

Date Signature of Patient/Parent/Guardian