Wesley Ryan, MD, and Associates

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NEW PATIENT REGISTRATION

We strive to provide the best quality care, and part of that is sharing with you the office policies and procedures, privacy policy, payment policy, and fee structure. We also need to collect some essential information from you. Please read and fill out this document in its entirety, and submit it prior to your first appointment. You may fax or email a scanned copy, but please note e-mail is considered an insecure method of communication. Thank you!

Full name (including middle name): Date of birth: / /
Address:

Email: Phone number:

Emergency contact:
Name: _____ Relationship: _____ Phone: _____

Who referred you here?

Primary Care Physician:
Doctor's name:_____ City/State:_____ Phone: _____

Please list names and contact information for any doctors that have been significantly involved in your care over the last few years:
Doctor's name:_____ City/State:_____ Phone: _____
Doctor's name:_____ City/State:_____ Phone: _____

Please list any drug allergies and reactions:
Drug/reaction: _____
Drug/reaction: _____

Check boxes for any health insurance you have:
[ ] Medicare: _____ [ ] I do not have Medicare [ ] I do not have any insurance
[ ] Medi-Cal: _____ [ ] I do not have Medi-Cal
[ ] HMO plan: _____ [ ] PPO plan: _____

I certify the above is correct to the best of my knowledge, and understand that the office is not accepting new patients with Medicare or Medi-Cal insurance, that these insurances do not provide coverage for services at this office, and such services instead are funded fully out-of-pocket by the patient. I will inform the office if I am applying or expect to gain such insurance.

I have read, understand, and agree to the above, and further consent to office staff leaving messages at the above phone number and/or email.

Signature: _____ Date: _____

OFFICE POLICIES AND PROCEDURES

Consent for Treatment and Treatment Issues
The first three appointments constitute a consultation. All treatment is strictly voluntary and you may choose to stop treatment at any time you wish. If you experience any problem or side effect with medication and/or psychotherapy, it is your responsibility to communicate this to your provider. Visits are scheduled on a frequency corresponding to medical need; more acute or complex issues warrant more frequent appointments (typical intervals range from weekly to as long as every 2-3 months). Patients who are repeatedly unable to keep appointments or are non-compliant with the mutually agreed upon treatment plan may be referred to another physician for continued care.

Appointment cancellation and reminders
Please provide 2 business days notice for any appointment cancellations. For example, to reschedule an appointment for Monday at 1pm, notice should be provided by the prior Thursday at 1pm. This allows other patients to be better accommodated at that time. **Missed appointments, or those canceled with insufficient notice, will be charged the full appointment fee**. As a convenience, appointment reminders are sent out automatically by email, SMS, and/or voice call 1 week, 36 hours, and 1 day prior to your scheduled appointment. You consent to receive such reminders, but please do not solely depend on them as sometimes they get filtered out as spam, or may not get to you as intended; ultimately it is your responsibility remember appointment times. Further, it is your responsibility to contact the office if you notice a discrepancy between the reminder and what you understood to be agreed upon. Missed appointments will be charged the full appointment fee. Late arrivals will be accommodated when possible, but arrivals 15 minutes or more after the scheduled time may require rescheduling in addition to the appointment fee for the original appointment.

Methods of communication
When contacting the office or leaving messages, please provide your full name, date of birth, and phone number / email where you can be reached. For prescription refills, see the next section below. Telephone calls and emails from established patients are generally returned within three business days, and often sooner. Please note e-mail is inherently not a secure method of communication, but with your consent here we are able to utilize it for the sake of convenience. Please avoid text messaging and instead email or call instead.

Prescriptions and refills
Please **be aware of how much medication you have remaining, and request refills from your pharmacy a week or more before running out** to allow time for the refill process. Regarding schedule II controlled substances prescriptions (where refills are not allowed by law), **make sure to bring this up with your provider during your scheduled appointment.** If you are in need of additional medication refills, and do not have any more remaining , please call your pharmacy and request it from them. They will contact the office with the details, and facilitate a provider authorizing it. After trying this and checking with the pharmacy 2-3 days later, if your medication is still not available, contact the office and make sure to specify: the pharmacy, their phone number, your name, your date of birth, medication name, and the medication dose. Please note, **medication refills are typically declined if you have canceled recent appointments and not rescheduled**. Regular visits are important to assess for medication side effects and benefits. Physicians are generally not allowed to practice in states they are not licensed in, so please be aware and request prescription refills prior to travel or vacation if you think you may run out during that time. You further consent for the automated and/or manual retrieval by providers of your prescription history via the electronic health record system (practice fusion).

Controlled substance prescriptions
Medications with a potential for abuse (stimulants, benzodiazepines, buprenorphine, etc) are known as

controlled substances and more tightly regulated by the DEA. Prescriptions for controlled substances are required to be hand written or e-prescribed, and typically require an in-person visit. Please note that schedule II controlled substance prescriptions (stimulants such as amphetamine or Adderall, etc) are prohibited by federal law from having any refills. Also note that pharmacies are required to log and providers required to check state database records for controlled substance fills (the CURES program in California). If you are prescribed a controlled medication you agree to:

- **Store your medication securely** (ideally in a locked box out of view), use only as directed, and **do not change the dose of your medication on your own.**
- You are expected **not to share your medication** with others. It is illegal for anyone other than yourself to use your prescribed medication.
- **Bring in your last fill to each and every appointment for pill counts.**
- **Random urine toxicology testing.**
- **Early refills will not be provided except under exceptional circumstances**. If your prescription is stolen, you must provide a police report to the office before an early refill can be considered. We will not refill for lost or misplaced prescriptions, because of exceeding the prescribed dosage, or because another family member has stolen, used, or discarded medications.
- **Not seek out the same or similar medications from other physicians.** Please note the prescription drug monitoring database is a log of such medication fills that physicians are required to routinely check in order to prevent this.
- **Inability to meet the above requirements may result in taper or transition to another medication.**

Emergencies and hospitalization
Should there be an emergency or concern for imminent health or safety of yourself or another person, call 911 or go to the nearest emergency room immediately. Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff do not have admitting privileges at nearby hospitals, though should you need admission, they are able to communicate with the inpatient team to let them know about your prior treatments and history.

Licensure and notices
In California therapists are licensed for the practice of psychotherapy by the Board of Behavioral Sciences (www.bbs.ca.gov/) and the Board of Psychology (www.psychology.ca.gov/). Associate therapists are registered and pre-licensed, and working towards full licensure under clinical supervision.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Notice and acknowledgment of receipt and understanding
Notice To Patients: Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

Staff and associates include (but are not limited to): Alan Hanft, M.D., Wesley Ryan, M.D., Erica Siegal, LCSW

I have read, understand, and agree to all of the terms of the office policies and procedures listed above (including both this page and the page immediately prior).
Signature: _____ Date: _____

CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I authorize staff at Wesley Ryan, MD, and Associates to discuss my psychiatric/mental health care with prior and current healthcare providers. I am aware that this information may pertain to my lab results, psychiatric condition, and/or treatment of substance abuse.

I further authorize discussion with the following party/parties (please list family members or friends that you may want to include in your treatment):

1. Name: _____ Relationship: _____ Phone: _____

   Address: _____

2. Name: _____ Relationship: _____ Phone: _____

   Address: _____

3. Name: _____ Relationship: _____ Phone: _____

   Address: _____

4. Name: _____ Relationship: _____ Phone: _____

   Address: _____

5. Name: _____ Relationship: _____ Phone: _____

   Address: _____

- **I understand such authorization to external parties is voluntary and not a condition of treatment.**
- **I further understand that I may revoke this consent in writing at any time except to the extent that action has been taken**
- **I understand I have a right to receive a copy of this authorization**
- **I understand that if the entity authorized to receive the information is not someone who is legally required to keep information confidential, it may no longer be protected by state or federal privacy regulations**

Signature: _____ Date: _____

PAYMENT POLICIES / FEES / INSURANCE BENEFITS

Payment for services is due at the time of service. We do not participate as a contracted provider for any insurance company, but are considered "out of network" for which many PPO insurance plans may partially reimburse (varies, depending on your plan). You may request a detailed receipt for each visit, called a superbill, that you can then submit to your insurance company for reimbursement. Certain services or medications (such as those used off label, or considered experimental) may not be covered by insurance at all, such as ketamine, and so reimbursement for this should not be expected. Please note associate therapists are registered and pre-licensed therapists working under supervision towards full licensure; services provided by them are generally not covered by insurance, so no out of network reimbursement is possible.

For new patients, we accept cash and major credit cards, and require a valid credit card be kept on file. Any outstanding fees will be charged to the card designated on this form. Established patients may opt to pay with check, however any overdrawn checks will incur a $50 fee to cover banking and administrative fees. Please contact the office with questions about any charges; erroneous charges will be refunded in full. Any disputed credit card payments that are ultimately found to be invalid will incur a $100 fee to cover administrative expenses; please contact the office directly if you feel a charge has been made in error. Initial scheduling payments may be made online at www.wesleyryanmd.com/payment and a valid credit card is required to be kept on file. Appointments canceled less than 2 business days prior to the scheduled time will be charged for the full price of the appointment; insurance companies typically do not reimburse for missed appointments. Patients who arrive 15 minutes or more late to an appointment may need to reschedule and are responsible for the full cost of the original and future appointments. In some circumstances, such as home visits, you will be charged at the time of scheduling. The fees and corresponding CPT codes are as follows:

Physician visits (M.D., D.O, etc.):

- Initial medical/psychiatric evaluation (1 hour) $585
- Initial evaluation: child / adolescent (1.5 hours) $850
- Medication management follow up (½ hour) $290
- Medication management + psychotherapy (1 hour) $450
- Ketamine-assisted psychotherapy (1 ½ hours) $720
- Ketamine-assisted psychotherapy (2 hours) $950
- Family / couples therapy (1 hour) $450

Therapist visits (LCSW, LMFT, LPCC, etc.):

Psychotherapy (1 hour) $325 Ketamine-assisted psychotherapy, SL (2 hours) $650

Miscellaneous:

- Home visits (including driving), forms, letters, and phone calls, prorated to time $585/hour
- Court / expert witness testimony request fee schedule
- Medical record request fee $15
- Missed appointment / no show / late cancellation full fee

Credit card number: _____ Security code: _____
Cardholder name: _____ Expiration date: _____
Billing address: _____ Phone number: _____
Signature (if different from below): _____ Date: _____

I have read, understand, and agree to all of the terms of the appointment change, cancellation fee, and no-show policy as outlined above and authorize Wesley Ryan, MD, and Associates to charge my credit card accordingly.
Signature: _____ Date: _____

PRIVACY POLICY

Authorization to release patient health information for treatment, billing, or healthcare operations
I understand that Wesley Ryan, MD, and Associates reserves the right to change the notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. In the event of a potentially life threatening emergency, I understand that staff are not required to adhere to these requested restrictions. Records may be needed in order to process a claim for medical services. I authorize providers to release information needed for billing purposes to entities that may provide services pertaining to my physical visit, such as laboratories or imaging suites, or to my payment, such as payment processors or insurance companies. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of billing, treatment, or pertinent healthcare operations.

Privacy and release of information
Doctor patient confidentiality forms an important foundation of medical and therapeutic care, and is protected under law. Services that you receive in this office are held in strict confidence, except in the following circumstances:
-Imminent threat of harm to yourself or others, or grave disability. In these cases, if your provider believes these to be of sufficient magnitude, they may refer you to emergency treatment.
-Mandated reporting: such as for the abuse of a vulnerable adult, child, or developmentally disabled person.
-A court order from a judge to release information.
-Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen days of the request.
-If you will be submitting a claim to your health insurance, we may be required to submit information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for those services.
-If you are involved in a child custody litigation at any time in the future, the court may order release of information about your treatment.
You will generally be contacted or informed about any of the above. In circumstances other than these, information about your treatment will not be released without your prior authorization.

Patient Records
A secure electronic medical record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain uncommon circumstances where seeing the record may put a patient or other person at risk, your provider may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Consent for email / text messages
I understand that email is inherently insecure. Wesley Ryan, MD, and Associates cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentiality caused by Wesley Ryan, MD, and Associates or a third party. I understand that Wesley Ryan, MD, and Associates has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I further understand and agree that in the event of emergencies, email will not be used and I will instead call 911. I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with physician and/or office personnel by email and/or text message.

I have read, understand, and agree to all of the terms of the privacy policy.

Signature:_____ Date:_____