Ye Beverly Du, MD, MPH, PLLC

PSYCHIATRIST-PATIENT SERVICE AGREEMENT (Effective July 1, 2018)

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHIATRIC SERVICES

Building and maintaining a healthy and collaborative doctor-patient relationship is central to my philosophy of the practice of medicine. I am committed to respecting your right to choosing the best treatment for you, to acting in your best interest, to promoting more good than harm (i.e. not be the cause of harm), and to treating you with fairness and equality. Specific to my practice, treatment will primarily (although not exclusively) occur through the modalities of psychotherapy and psychotropic medications.

Psychotherapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following paragraph.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will

happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

All psychotropic medications (antipsychotics, antidepressants, mood stabilizers, sedatives, stimulants, etc.) also have both benefits and risks. The decision to take medication typically involves balancing possible benefits against possible side effects that I will discuss with. Researchers believe that the symptoms of mental illness come from chemical imbalances in a person's brain, and a medication works on these imbalances to reduce the symptoms, or possibly relieve them completely.

It is important to be aware that medications are not cures. Medications only treat symptoms, so if you stop taking them, symptoms may return if the root cause has not yet been fully addressed. Medications often help the most when they are part of an overall treatment program (e.g. psychotherapy, peer support programs, rehabilitative services, etc.), to help with problems that medications alone cannot treat. Most medications take a few weeks to work, sometimes a medication's side effects may start before you experience the benefits, and you may have to try more than one medication before you find the right fit.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan, including treatment with psychotropic medications as appropriate. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be glad to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments following our initial appointment will ordinarily be 45 minutes in duration, at least once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with **24 hours notice**. If you miss a session without canceling, or cancel with less than 24 business hour notice, my policy is to charge for the session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee as described above. If it is possible, I will try to find

another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

In order for me to remain your prescribing provider and to offer the quality of care you deserve, I will need to see you at least once a month if you are on a controlled substance and at least once every three months if you are on any other types of medication, unless a specific exception is made for extenuating circumstances. If for whatever reason I am unable to see you at this frequency, I will do my best to refer you to another provider who might better meet your needs.

PROFESSIONAL FEES

The standard fee for each 45 minute session is $275.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check or cash. I am also able to process credit card charges as payment; however, the convenience fee charged by the credit card processor will be added to any credit card charges made. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay a rate of $1000 per hour for the professional time required, even if another party compels me to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I am considered an out-of-network provider for insurance plans. If you desire to use insurance,
I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement of a portion of your fee if you have out-of-

network benefits. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychiatric services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, your medications, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

CONTACTING ME

I welcome telephone and email communications for logistical and scheduling information only. I cannot guarantee that information exchanged over phone or email will be secure. Phone and email communications will not replace in-person appointments when you are unable to make your appointment. It may take one to two business days for non-urgent matters. If, for any number of unseen reasons, you do not hear from me, I am unable to reach you, you feel you cannot wait for a return call, or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make

every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are dissatisfied with what is happening in your treatment, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another psychiatrist and are free to end treatment at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of the treatment and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with patients or with former patients.

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

- Disclosures that constitute a sale of PHI under HIPAA; and

•Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

•The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

•The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

•The right to inspect and copy your PHI.

•The right to amend your PHI.

•The right to receive an accounting of disclosures of your PHI.

•The right to obtain a paper copy of this notice from us upon request.

•The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of January 1, 2018 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

CONSENT TO TREATMENT

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Date _____

Description of Personal Representative's Authority:_____

_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Ye Beverly Du, MD, MPH, PLLC

I am a patient of Ye Beverly Du, MD, MPH. I hereby acknowledge receipt of Dr. Du's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____ Date: _____