

Bruce Hubbard, M.D., Inc.

Welcome to our office. We encourage any inquiry you may have about our professional training, experience, and what you can and cannot expect from treatment. This packet has been prepared to give you information about our treatment fees and policies. Please ask any questions you might have about this packet *before we begin your evaluation.*

Our office is committed to the highest quality of professional care and the briefest duration of such care consistent with managing your personal situation. Following your initial assessment, we shall inform you of our proposed treatment plan. If you do not agree with this plan, it is your responsibility to inform us of this. If you do not wish to continue treatment with us, we shall be accommodating in referring you to other professionals.

Please be aware that we strive to be available on time for all our patients' appointments, so please plan to arrive on time (or early) when scheduled. If you are more than five minutes late for an appointment, we will reschedule you so that the appropriate time necessary for a thorough initial or follow-up visit is available.

We look forward to meeting you personally.

Bruce Hubbard, M.D.
Rizwan S. Khan, PA-C
Ann Wycoff, Ph.D.

Acknowledgement of Disenrollment from Medi-Cal

Please note that Dr. Hubbard disenrolled from Medi-Cal in April of 2015. This office does not bill Medi-Cal for any services.

If you are a Medi-Cal eligible recipient, you will be required to pay out of pocket for any services rendered here by either cash, Mastercard, Visa or American Express credit cards.

If you have any insurance primary to Medi-Cal, this office will bill that insurance for you; however, you will be responsible to pay any co-payment, deductible, or co-insurance amounts that your primary coverage does not pay. No show or late-cancellation fees (\$75) will also be your responsibility.

If you have no other insurance to be billed, the fee for service is \$150. If you cannot afford these charges, it is your right to seek treatment from another provider.

Should you need to change providers, upon notification of your need to seek care elsewhere, a 30-day refill of your medication(s) will be called into your pharmacy. It is your responsibility to get scheduled with a new provide right away to avoid running out of medication.

I understand the above and acknowledge that I am seeking treatment from a doctor which does NOT accept Medi-Cal. I agree to pay the cash rates for any services rendered, or any amounts due after my primary coverage has been billed and which is left owing by me to Dr. Hubbard.

Contract of Confidentiality

I understand that the professional rules of strict confidentiality will apply to my treatment by Bruce Hubbard, M.D., and Rizwan S. Khan, PA-C. These rules will be waived only in cases wherein legal proceedings are part of the evaluation process, e.g. child custody matters, court-ordered examination, examinations at the request of civil service bodies.

Accordingly, I understand that Dr. Bruce Hubbard, Dr. Wycoff, and Rizwan Khan will not discuss the content of our sessions with anyone, unless I request them to do so in writing.

I understand that the law of California does not fully recognize the right of the patient to psychiatric confidentiality. Your visits are confidential with the following legally mandated exceptions:

Information regarding suspected child abuse, elder abuse, or dependent adult abuse must be reported immediately.

Privileged doctor-patient communication is waived if you bring the facts of your visit into court.

There may be no confidentiality if you become a danger to yourself or others.

Your insurance or managed care company may request information necessary to process your claim and/or for quality assurance reviews.

I waive the confidentiality of diagnosis and prognosis as required by my insurance company for payment of medical fees. This I will indicate by preparing and signing the patient portion of the insurance form.

I also acknowledge, should I choose to email the office or ask the office to email me for any reason, that email is not a confidential form of communication.

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Bruce Hubbard, M.D, Ann Wycoff, Ph.D. or Rizwan Khan, PA-C, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of Bruce Hubbard MD Inc.

I understand that my diagnosis or treatment of me by Dr. Bruce Hubbard, Dr. Ann Wycoff, or Rizwan Khan, PA-C, may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Bruce Hubbard, Dr. Ann Wycoff, or Rizwan Khan, PA-C are not required to agree to the restriction that I may request. However, if Dr. Bruce Hubbard, Dr. Ann Wycoff, or Rizwan Khan, PA-C has agrees to a restriction that I request, the restriction is binding on them.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Bruce Hubbard, Dr. Ann Wycoff, or Rizwan Khan, PA-C, has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bruce Hubbard MD Inc.'s Notice of Privacy Practices prior to signing this document. A copy of the Notice of Privacy Practices is available at <http://brucehubbardmd.com>.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Bruce Hubbard MD Inc.'s practice.

The Notice of Privacy Practices also describes my rights and the duties of Dr. Bruce Hubbard, Dr. Ann Wycoff, and Rizwan Khan, PA-C, with respect to my protected health information.

Bruce Hubbard MD Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Bruce Hubbard, M.D., Inc.

Authorization for Medical Services and Contract for Payment

I authorize and direct Dr. Bruce Hubbard, Dr. Ann Wycoff, and/or Rizwan Khan, PA-C, to perform such therapeutic procedures that, in their judgment, may be indicated or may be advisable for my well-being. I understand that no warranty or guarantee is made as to the results of this treatment.

I hereby agree to pay for the services that are rendered as indicated. My signature indicates that I have reviewed the fee schedule and accept the same. I understand that should I not pay for services, I will pay the total cost of services to obtain the same, including the fees charged by a collection agency, attorney fees, court costs, and costs of process servicing (these costs may be added to the basic fees and any accrued late payments or interests).

I understand professional fees are payable upon completion of services rendered. Payment for services is the patient's responsibility (or parent/guardian, if patient is a minor.) **I agree to pay my share of the charges, such as co-payment and deductible amounts, at the time of each visit.** The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. I understand that Russell Bruce Hubbard, MD, Inc.'s fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please review the Schedule of Fees below, or ask the office staff. Please note that this office charges a \$25 service fee for all returned checks.

Failure to pay will result in a service fee accumulating at the rate of 1% per month on the unpaid balance. Should I fail to cancel an appointment 24 hours or more in advance, I understand that I will be held responsible for a \$75 fee for that visit. If I owe fees for missed or late-canceled appointments, I understand that I must pay those fees before or at my next scheduled appointment.

This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s).

I understand that if that our providers are to effectively treat me, I will need to comply with all requests for medical and psychological information. If I do not comply with these requests or do not comply with treatment recommendations, I understand that our providers are under no obligation to continue treating me.

If there are any questions regarding the billing, I can call the billing office at (619) 464-1165. If no one is available, I can leave a message and my call will be returned.

Schedule of Fees

Initial Evaluation and Consultation (30 minutes)	\$300.00
Medication Management (15 minutes)	\$150.00

If accessing insurance benefits for your appointments, you will be responsible for the co-pay or co-insurance amount verified by telephone at the time of your initial visit. Should the insurance company's Explanation of Benefits form to you and/or insurance claim payment to us detail a different amount due for these services, you will be responsible for payment of that amended amount at the time of each visit. In the event that your insurance coverage is terminated, you understand that the above fee schedule will apply to your visits.

General Policies and Patient Responsibilities

Billing Information: It is important to me that my patient understand my fees and possible methods of payment. Payment for each visit is requested at the time of service. You may pay by cash, check, American Express, MasterCard, or Visa. If you have insurance coverage, we will submit a claim for services to your insurer. If your copay or insurance has not been verified, we require full payment at the time of service. I wish to stress that the financial responsibility for services rendered rests with you, regardless of any insurance coverage.

Appointment Responsibilities:

Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment with at least 24 hours advance notice I may be billed for the full fee at the discretion of Russell Bruce Hubbard, MD, Inc. I understand that insurance companies do not cover missed appointments. **I agree to be on time for my appointments.** **If I arrive late for a scheduled appointment, Dr. Hubbard may not be able to see me and I will be charged a late cancellation fee.**

Reminder calls or texts are placed whenever possible ***as a courtesy only***. Time does not allow for more than two attempts if we are unable to reach you due to a busy line, no answer, or no or full voicemail box. Not receiving a call or text from us in no way relieves you of your responsibility to keep your appointment. You will not be able to bill your insurance or workers' compensation carrier for the late cancellation or no-show fee. In case of a Monday appointment, you must phone our office by 5:00 p.m. on Friday.

Medication Policies:

I understand that medication refills will be considered during office hours only. This is so this office can conform with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of Russell Bruce Hubbard, MD, Inc, or obtaining medication illegally. **I further understand that if I should need to have a prescription refilled that I should contact my pharmacy at least 7 days prior to needing the medication or the medication may not be available to me the same day.** I understand refills for any medication will not be performed unless I have been seen within the last six months.

If Dr. Hubbard or Rizwan Khan, PA-C prescribes a medication for you that is a "controlled substance" (such as sleeping medication or medication for Attention Deficit Disorder, but not limited to these), please ***be very careful not to lose the prescription form or the medication*** because it cannot be replaced until the date it would have run out. Also, prescriptions for controlled substances ***cannot be filled early***, i.e., before you would have run out of the previous prescription. **There are no exceptions to this policy.**

It is important that you realize that many medications are prescribed "off-label." This means that they are prescribed for conditions for which they are commonly used but for which they have not been formally approved by the Food and Drug Administration (FDA). These medications are approved for a number of conditions, and this is **NOT** an experimental use of these medications. Dr. Hubbard or Rizwan Khan, PA-C, will be pleased to answer any questions you might have about this practice.

Bruce Hubbard, M.D., Inc.

Disability Insurance Policies: If you need continuation of disability benefits or are started on disability by this office, there may be a fee for disability paperwork preparation.

Short-term or long-term disability documentation (thru employer): \$50

Initial Certification or Recertification of State Disability (EDD): \$25

This fee is due at the time of your visit and is not covered by your medical insurance.

Medical Records: I understand that Russell Bruce Hubbard, MD, Inc will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party.

Agreements

I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me.

I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered.

In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90-days from the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account.

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs.

By using my Patient Portal online document signature, I acknowledge that I have read this set of policy statement, specifically including:

- **Acknowledgement of Disenrollment from Medi-Cal**
- **Contract of Confidentiality**
- **Consent for Purposes of Treatment, Payment, and Health Care Operations**
- **Authorization for Medical Services and Contract for Payment**
- **Schedule of Fees**
- **General Policies and Patient Responsibilities**

and I furthermore agree to the terms as stated.