Hi and welcome to the practice! Please keep this page for your records.

1. SAFETY- (we have to spell this one out) If you are having a life threatening emergency please immediately dial 911 and get help. Do not email or call us first.

2. REFILLS - Please ask you pharmacist to transmit a request ELECTRONICALLY (e-prescription). Please plan ahead with refills as we are closed on Wednesdays and weekends. After-hours refill requests will incur a $50 charge for time spent in process.

3. MEDS: In many cases, paying cash may be less expensive than insurance. Please always check medication prices on **GoodRx.com**, before requesting a prior authorization (often many medications will be less expensive without use of insurance). We will always inform you of higher cost, non-generic medications, when we prescribe and do our best to minimize cost.

4. APPOINTMENTS: Please consider booking several appointments in advance as our schedule does get full – usually 3-4 weeks going forward. We will always do our best to accommodate, but it helps to plan, as more options are available. Initially, meeting every 1-2 weeks is optimal, and we begin to space out appointments as things improve. Once in the practice, you are free to see any of our providers. You can always schedule online at www.siliconpsych.com - click "Schedule A Visit."

5. CONTACTING US
    a. OFFICE PHONE 650-326-5888 or FAX 650-326-5889

    b. EMAIL: info@Siliconpsych.com

    c. BOOKING APPOINTMENTS (two options) – please book ahead
        1. ONLINE www.siliconpsych.com - "Schedule A Visit,"
        2. Call us at 650-326-5888 or let us know in person

    d. *URGENT* matters only (not life threatening)

1. Business hours (9-5pm, closed Wed)	650-326-5888
3. After hours - Alex Dimitriu, MD:	917-225-7146
4. After hours - Lauren Varma NP:	207-242-2641
5. After hours- Susan Smith MD:	650-283-9117
6. National Suicide Prevention Hotline	800-273-8255

Everything we do here is aimed to make your life easier. If there is any way we can do this better, please let us know. **If we've done something amazing, please consider leaving us a positive review.**

SERVICE FEE STRUCTURE

Initial Consultation and Standard Visit Rates

Initial visit may require 1-2 hrs depending on complexity
$800/hour with Alex Dimitriu MD ($400 per 25 minute follow up visit)
$500/hour with Susan Smith MD ($250 per 25 minute follow up visit)
$400/hour with Lauren Varma, NP ($200 per 25 minute follow up visit)
$200/hour with Palak Kothari, PhD
$50 – after hours refill requests

I understand that as a courtesy to the provider, if for any reason, a 30 minute appointment must be cancelled by the patient, 48 hours notification by phone or email will be given to the physician's office (two working days; weekend days and holidays do not count).

For one hour appointments, cancellation is required 5 working days in advance. Failure to properly notify the provider will result in charges at the usual rate for that appointment. Such charges are not reimbursed by insurance programs.

Once admitted into the practice, our patients are free to be seen by any of the providers at the above respective rates. We actually encourage you to do so, as we each have our strengths.

I agree with the above terms, as indicated by my signature below.

_____ _____

PATIENT SIGNATURE **DATE**

REGISTRATION FORM

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SEX

ADDRESS (STREET & NO)	CITY	ZIP CODE

EMAIL ADDRESS

HOME PHONE	MOBILE PHONE	WORK PHONE	SOCIAL SECURITY

MARITAL STATUS	DRIVER'S LICENSE NUMBER	IS YOUR CONDITION WORK-RELATED? IF YES DATE CLAIM FILED WITH EMPLOYER..

EMPLOYER/OCCUPATION	EMPLOYER'S ADDRESS

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT

PHONE NUMBER OF EMERGENCY CONTACT	CONTACT'S ADDRESS

INSURANCE COMPANY	INSURANCE COMPANY PHONE NUMBER	INSURANCE IDENTIFICATION NUMBER

PRIMARY CARE PHYSICIAN OKAY TO CONTACT?	PHONE NUMBER	ADDRESS

CURRENT THERAPIST: OKAY TO CONACT?	PHONE NUMBER	ADDRESS

ADDITIONAL PHYSICIAN OKAY TO CONTACT?	PHONE NUMBER	ADDRESS

REFERRED BY:

PATIENT SIGNATURE _____ DATE _____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I HEREBY AUTHORIZE: The office of Dr. Alex Dimitriu, MD
Physician/Healthcare Facility

To release/receive information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

TO COMMUNICATE WITH (Please consider primary care provider, therapist, or referral source):

Name

Address

Phone / Fax / Email

AND ALSO:

Name

Address

Phone / Fax / Email

The medical information/records will be used for the following purpose: relay and communication of medical information

DURATION This authorization shall be effective immediately and remain in effect until: _____
Date (or until cancelled in writing)

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient *or legal/personal representative* Date of Birth

Patient's Name (PRINT) Date

CREDIT CARD AUTHORIZATION

I, _____, hereby authorize the office of Alex Dimitriu, MD Inc, to charge my credit card account for regularly scheduled visits, missed or phone appointments or as otherwise indicated.

CREDIT CARD NUMBER _____

EXPIRATION DATE _____

SECURITY CODE _____

NAME ON CREDIT CARD _____

BILLING ADDRESS:

Name (exactly as on card) _____

Street: _____

City: _____ State: _____ Zip:_____

Telephone: (_____)_____ Mobile: (_____)_____

I understand that the doctor requires payment at time of visit by cash, check, bank transfer, or credit card. A valid credit card number will be required for our files. In the event of a late cancellation, missed or phone appointment, your card will be charged accordingly.

_____ _____
Account holder Signature Date

CONDITIONS OF TREATMENT AND FINANCIAL AGREEMENT

I understand that while the doctor will assist me in obtaining 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 the doctor's charges at time of services rendered.

I understand that because of the highly specialized nature of his practice, the doctor does not participate in any managed care programs such as health maintenance organizations, preferred provider plans, Medicare, workers compensation cases, or victim witness cases.

I understand that the doctor requests payment at time of visit by cash, check, or credit card. A valid credit card number is required for our files. In the event of a late cancellation, missed appointment, or phone appointment, your card will be charged accordingly.

I understand that as a courtesy to the physician, if for any reason a 30 minute appointment must be cancelled, **48 hours notification by phone or email** will be given to the physician's office (two working days; weekend days and holidays do not count). **For one hour appointments, cancellation is required 5 working days in advance**. Failure to properly notify the physician will result in charges at the usual rate for that appointment. Such charges are not reimbursed by insurance programs.

I understand that the doctor / staff may charge for telephone consultations, prescription refills, completion of forms, and for all other uses of staff time on my behalf, at the rates on the service / fee page.

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

I have read and understand the above agreement:

_____ _____

PATIENT SIGNATURE **DATE**

CONSENT FOR ELECTRONIC COMMUNICATION (EMAIL / TEXT /PHONE)

I, _____,

hereby consent to have Menlo Park Psychiatry and Sleep (office of Dr. Alex Dimitriu), to communicate with me via email, phone, Facetime ®, Skype ®, or other digital means of written, voice, or video electronic communication, with full knowledge that these may not be secured or HIPAA compliant methods of communication. We will make every effort possible to keep your information secure.

Additional communication may be required with members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

_____ _____

PATIENT SIGNATURE **DATE**

CONSULTATION SERVICE FOR NEW PATIENTS

The initial visit / evaluation is intended to be an opportunity to get to know each other and see how we can help you. Our aim is to determine if we are a good fit to be able to work together.

Admittance into the practice is at the discretion of Alex Dimitriu, MD Inc.

I, _____,

hereby acknowledge that services rendered by Menlo Park Psychiatry and Sleep (office of Dr. Alex Dimitriu,), are rendered as a consultation only service. As consultations only, such evaluation does not initiate or guarantee ongoing medical care, treatment, or admittance to the practice of Menlo Park Psychiatry and Sleep (office of Dr. Alex Dimitriu and fellow providers in the practice).

Additional coverage and follow up consultation are possible upon request and consistent with the enclosed fee schedule. The facility staff / physician or prior treatment provider (prior psychiatrist, primary care provider, or facility on call doctor) will remain the primary care provider for both urgent and non-urgent matters.

_____ _____

PATIENT SIGNATURE **DATE**