Hi and welcome to the practice!
KEEP THIS PAGE FOR YOUR RECORDS

1. Patient Registration- all the details about you
2. Fee Structure
3. Payment / credit card authorization- please be mindful-we bill for missed appointments. New Patient or ONE HOUR appointments must be canceled 5 working days prior, and follow up or 30 MIN appointments may be canceled up to 2 days prior.
4. Authorization for Disclosure – lets us communicate with your other docs
5. Financial agreement- your consent for treatment and payment.
6. Electronic communication- despite all our efforts, email is not always secure, but is quite convenient. This form acknowledges your awareness of this.
7. Consultation only form – for second opinions, consultations, or limited visits

Some additional helpful and contact information:

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/MEDS: Please ask you pharmacist to transmit REQUEST ELECTRONICALLY (e-prescription) or FAX REQUEST to 650-326-5889. Please allow 2 business days to process

3. **CONTACTING US**
   a. OFFICE PHONE or FAX 650-326-5888

   b. EMAIL: Alex@DoctorAlex.com or Lauren@DoctorAlex.com

   c. BOOKING APPOINTMENTS (two options)
      1. ONLINE www.doctoralex.com
      2. Call us at 650-326-5888 or let us know in person

   d. *URGENT* matters only (not life threatening)
      1. Business hours (Mon,Tues, Thur, Fri 830am to 5pm
         650-326-5888
      3. After hours - Dr. Dimitriu: 917-225-7146
      4. After hours – Lauren Varma NP: 207-242-2641

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 write a positive review!**

SERVICE MODELS / FEE STRUCTURE

Initial Consultation and Standard Visit Rates

Initial visit may require 1-2h depending on complexity
$600/hour with Alex Dimitriu MD ($300 per 25 minute follow up visit)
$400/hour with Lauren Varma, NP ($200 per 25 minute follow up visit)

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

Following initial consultation, clients may **choose from the options below:**

Standard per visit plan – Pay as you go

- Alex Dimitriu, MD - $600/ 50-minute appointment and $300/ 25-minute appointment
- Lauren Varma, NP - $400/ 50-minute appointment and $200/ 25-minute appointment
- We require patients be seen at least once per 3 months (4x/year) to maintain our working relationship

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: Alex Dimitriu, MD, and / or Lauren Varma, NP
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:

_____
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 an 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 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 rate of $300 per 25 minutes.

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 Alex Dimitriu, MD Inc.

I, _____,

hereby acknowledge that services rendered by Menlo Park Psychiatry and Sleep (office of Dr. Alex Dimitriu, Lauren Varma NP), 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, Lauren Varma, NP).

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**