Michael Hwang, M.D.
3620 Birch St. Suite 210
Newport Beach, CA 92663

Phone/Fax/SMS: **949-207-6775**
Michael@psychiatryOC.com

www.psychiatryOC.com

Office Policies

In order to prevent any misunderstanding concerning your psychiatric care, including contact in between sessions, cancellation policy, responsibility for payment for services provided, please read the following information carefully:

EVALUATION AND TREATMENT

First we need to clarify what the problems are and what treatment would be best for you. After the initial assessment, we will discuss the risks and benefits of treatment options, which may include therapy or medication treatment, or a combination of both. If you feel it is not possible for us to work together for any reason, I will do my best to refer you to other mental health clinicians better suited for your needs.

FEES

Initial Evaluation – 60 to 90 minutes: $600

Follow-up Sessions (With or without medication): 25-30 minutes: $250

PAYMENTS

Payment for services provided is due at the end of each session (cash, check, credit/debit cards). If your account has payment overdue for over 60 days, legal means will be considered to secure payment, including collection agencies or small claims court. There will be a $25.00 service charge for all retuned checks.

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to pay for it unless you provide at least **24 business hours** advance notice of cancellation. If you do not provide at least 24 business hours notice, or fail to show for a scheduled appointment, you will be responsible for the **full** cost of the session. Insurance companies will often not reimburse for missed sessions or sessions cancelled late.

INSURANCE REIMBURSEMENT

I am considered an “out of network provider” for PPO plans. Please be aware that your health insurance policy is an agreement between you and your insurance company. All charges are your responsibility, whether or not you have insurance. I will provide you with a statement that can be submitted to your insurance company. Please find out from your insurance company exactly what mental health benefits are covered.

Initials _____

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CONTACTING ME

All calls to my office number are answered by voice mail. I do check for messages frequently throughout the day, even on weekends, and return phone calls by the next business day. You are welcome to email or text me, but I do not check for messages as regularly as I do with voicemail messages, and therefore, I cannot guarantee that I will respond to email or text messages in a timely manner. Please be aware that email is not a secure medium. Please contact me with questions or concerns about medication supply. If you missed or could not make an appointment, you will be given enough medication to last until our next rescheduled session, usually within 2 weeks.

Please call 911 or go directly to nearest emergency room in event of a psychiatric or medical emergency.

PATIENT RECORDS

Both the law and the standards of my profession require that I keep appropriate treatment records. You are entitled to review a copy of the records, unless I believe seeing them would be emotionally damaging, in which case, I will be happy to provide them to an appropriate mental health professional of your choice. Because these are professional records, they can be misinterpreted or upsetting, so I recommend that we review them together so that we can discuss what they contain. I can also prepare an appropriate summary for review.

CONFIDENTIALITY

Confidentiality is of utmost importance in mental health treatment and is protected by the law. I can only release information about our work to others with your written permission. For child and adolescent patients, their trust in me is paramount. Before discussing a sensitive issue with the parent I will first get the minor's permission. I generally try to help the child/adolescent to discuss any sensitive matters with their parents themselves.

There are exceptions to confidentiality where disclosure is required by law. These are:

- Threat of harm to self
- Threat of harm to others
- Inability to care for your basic needs (food, clothing, shelter)
- Indication of possible abuse to a child, elderly person, to disabled person

In the event of any of the above, I may have to contact other parties (ie. family members, state agency, police, or hospital) in order to protect you or someone else.

PRACTICE STATUS

I share an office suite with other mental health professionals. With regard to your clinical care, I am completely independent and solely responsible. My clinical records are separately and securely maintained.

I have read and understand all the information above. I agree to evaluation and/or treatment by Dr. Michael Hwang, that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

Patient name: _____

Name of responsible party (if other than patient): _____

Signature of patient/responsible party: _____ Date: _____

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PATIENT INFORMATION FORM

LAST FIRST MI — NAME

YYYY MM DD — BIRTHDATE

☐ M ☐ F — GENDER

STREET

CITY, STATE

COUNTRY, ZIP CODE — ADDRESS

SOCIAL SECURITY NUMBER

☐ SINGLE ☐ DIVORCED ☐ WIDOWED
☐ MARRIED ☐ SEPARATED

RELATIONSHIP STATUS

EMAIL ☐

HOME PHONE ☐

WORK ☐

CONTACT INFORMATION. PLEASE INDICATE PREFERRED METHOD OF CONTACT ☐

RELIGIOUS/SPIRITUAL BACKGROUND

HIGHEST LEVEL OF EDUCATION / DEGREE / SPECIALIZATION

NAMES AND AGES — CHILDREN (IF APPLICABLE)

OCCUPATION

NAME

OCCUPATION — SIGNIFICANT OTHER'S NAME & OCCUPATION (IF APPLICABLE)

NAME

PHONE

STREET ADDRESS

CITY, STATE

COUNTRY, ZIP CODE — PRIMARY CARE PHYSICIAN

1. NAME

PHONE

RELATIONSHIP

2. NAME

PHONE

RELATIONSHIP — EMERGENCY CONTACTS

SIGNATURE: _____ DATE: _____

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HOW DID YOU HEAR ABOUT Michael Hwang MD?

PLEASE DESCRIBE THE REASON FOR SEEKING TREATMENT (INCLUDE DATE/MONTH THE PROBLEM BEGAN)

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST MONTH:

- ☐ DIFFICULTY FALLING ASLEEP
- ☐ DIFFICULTY STAYING ASLEEP
- ☐ EARLY MORNING WAKENING
- ☐ DECREASED ENERGY/FATIGUE
- ☐ APPETITE CHANGE- INCREASED OR DECREASED
- ☐ WEIGHT- LOSS OR GAIN
- ☐ HOPELESSNESS/HELPLESSNESS
- ☐ LOSS OF INTEREST
- ☐ SEXUAL DYSFUNCTION
- ☐ TEARFULNESS
- ☐ DEPRESSED MOOD
- ☐ POOR CONCENTRATION
- ☐ MEMORY DIFFICULTIES- SHORT TERM
- ☐ MEMORY DIFFICULTIES- LONG TERM
- ☐ TROUBLE ORGANIZING THOUGHTS
- ☐ FEELINGS OF GUILT
- ☐ THOUGHTS OF HARMING YOURSELF
- ☐ IRRITABILITY
- ☐ IMPULSE CONTROL PROBLEMS
- ☐ ANGER OUTBURSTS
- ☐ DECREASED NEED FOR SLEEP
- ☐ RECKLESS BEHAVIOR
- ☐ PROMISCUITY
- ☐ RACING THOUGHTS
- ☐ HYPERACTIVITY
- ☐ TALKING TOO FAST OR TOO MUCH
- ☐ NOT FINISHING PROJECTS
- ☐ EASILY DISTRACTED
- ☐ HEARING VOICES
- ☐ SEEING THINGS THAT ARE NOT THERE
- ☐ FEELING PARANOID
- ☐ OBSESSIVE THOUGHTS
- ☐ COMPULSIVE BEHAVIORS
- ☐ PERFECTIONISM
- ☐ SOCIAL ANXIETY
- ☐ PERFORMANCE ANXIETY
- ☐ SPECIFIC PHOBIA
- ☐ AGORAPHOBIA
- ☐ NERVOUSNESS/ANXIETY
- ☐ EXCESSIVE WORRY/FEAR
- ☐ PANIC ATTACKS
- ☐ HYPERVIGILANCE
- ☐ FLASHBACKS OF TRAUMATIC EVENT
- ☐ NIGHTMARES
- ☐ EATING DISORDER
- ☐ PREGNANCY RELATED MOOD DISORDER
- ☐ POSTPARTUM DEPRESSION
- ☐ POSTPARTUM PSYCHOSIS
- ☐ RELATIONSHIP DIFFICULTIES
- ☐ LEGAL TROUBLES
- ☐ THOUGHTS OF BRINGING HARM TO ANOTHER PERSON

LIST OF MEDICAL CONDITIONS

LIST OF SURGICAL PROCEDURES

YYYY MM DD
DATE OF LAST PHYSICAL EXAM

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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ALLERGIES

CURRENT MEDICATIONS (DOSE, FREQUENCY, PRESCRIBING MD)

VITAMINS/HERBS/SUPPLEMENTS

ALCOHOL

CIGARETTES

CAFFEINE

OTHER DRUGS (PLEASE LIST)

HOW MUCH OF THE FOLLOWING DO YOU CONSUME OR HAVE COMSUMED IN THE PAST

PREVIOUS PSYCHIATRIC DIAGNOSES/TREATMENT/MEDICATIONS

LIST OF PSYCHIATRIC ILLNESS IN ANY OF YOUR FAMILY MEMBERS

HAVE YOU EXPERIENCED ANY TRAUMA OR ABUSE (PHYSICAL, EMOTIONAL, SEXUAL, NEGLECT)

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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Acknowledgement of Receipt of HIPAA Document

I, _____, have received a copy of the Notice of Privacy Practices.
(Name of patient or guardian)

_____ _____ _____
(Signature of patient or guardian) (Relationship to patient) (Date)

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CREDIT CARD AUTHORIZATION FORM

LAST FIRST MI
PATIENT NAME

☐ VISA ☐ AMERICAN EXPRESS
☐ MASTERCARD ☐ DISCOVER
TYPE OF CARD

CREDIT CARD NUMBER

MM YYYY
EXPIRATION DATE SECURITY CODE

CARD HOLDER NAME (EXACTLY AS APPEARS ON CREDIT CARD)

CARD HOLDER PHONE #

STREET ADDRESS

CITY, STATE

COUNTRY, ZIP CODE
CREDIT CARD BILLING ADDRESS

I AUTHORIZE MICHAEL HWANG, M.D.; TO KEEP MY SIGNATURE ON FILE AND TO CHARGE MY CREDIT CARD FOR MISSED APPOINTMENTS AND ANY UNPAID BALANCES FOR SERVICES ALREADY RENDERED.

CARD HOLDER SIGNATURE: _____ DATE: _____

ALL CHARGES WILL APPEAR ON YOUR CREDIT CARD STATEMENT AS “SINA SAFAHIEH , M.D.”