CHRISTOPHER R. THOMPSON, M.D.
CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY IN GENERAL PSYCHIATRY,
CHILD & ADOLESCENT PSYCHIATRY, AND FORENSIC PSYCHIATRY, AND BY THE AMERICAN BOARD OF ADDICTION MEDICINE

CONSENT FOR EVALUATION AND TREATMENT

Thank you for considering entrusting your (or your child's) psychiatric care to me. I realize that choosing a psychiatrist is a very important decision, which is influenced by many factors. Please take a moment to review the information below. Do not hesitate to contact me if you have additional questions.

OFFICE LOCATION AND PARKING: My office is located on the 8th floor of the Avco Building, which is on the south side of Wilshire Blvd., 1½ blocks east of Westwood Blvd. Metered parking is available on Glendon Ave. south of Wilshire, but be sure to read posted signs. Parking is generally free after 8 PM. There is also a parking structure on the east side of Glendon, south of the Avco Building, which charges a flat rate of $3 for entrance after 5 PM. Additionally, there is an uncovered lot on the west side of Glendon, south of the Avco building, which charges a flat rate of $4 for entrance after 4 PM. The Avco Building does have parking available, albeit at substantially higher rates. The Avco Building parking entrance is on the east side of Glendon, just south of Wilshire Blvd. Please note that I do not validate parking.

FEE SCHEDULE: Initial evaluation (1½ hours): $720. Psychotherapy session (50 minutes): $400. Medication management appointment (25 minutes): $250. Meeting with parents/caretakers (25 minutes): $200. Meeting with parents/caretakers (15 minutes): $120.

PAYMENT ISSUES: All outpatient visits must be paid for at the time of the visit unless other arrangements have been made with me. I do not accept health insurance and am not a member of any managed care provider panels. However, I will provide patients/parents/caretakers with an invoice at the end of the month that includes charges, payments, CPT codes and DSM-5 diagnosis codes; most insurance carriers require this information for reimbursement. Patients/parents/caretakers can then submit a copy of this invoice, along with a claim form, to their health insurance company for possible partial reimbursement. Rates of reimbursement vary by insurance carrier and plan. Therefore, you may wish to check with your carrier prior to scheduling an initial appointment.

If you have made arrangements with me to be billed monthly, at the end of each month you also will receive a statement that includes charges, previous payments, CPT codes and DSM-5 diagnosis codes. The balance is due 15 days after the statement date. Any overdue balance is due upon receipt. There is a returned check charge of $25.

APPOINTMENT TIMES: Appointments will start and end at their scheduled times, regardless of when the patient arrives for the appointment. Frequently, I have patients scheduled back-to-back and am therefore unable to extend appointment times because it would be unfair to keep other patients waiting.

CANCELLATION POLICY: Should you need to cancel an appointment, please do so at least 48 hours in advance. Otherwise, you will be charged at the regular rate for the canceled/missed session unless this time slot can be otherwise filled with paid professional activity. Patients, parents, or caretakers obviously will not be charged for my vacations or other absences.

PHONE AND E-MAIL CONTACT: I am happy to return routine phone calls and e-mails free of charge. However, if returning phone calls and e-mails for a particular patient becomes frequent and time-consuming, I may ask the patient, parents, or caretakers to increase their frequency of appointments in order to address these issues during session times. Lengthy phone calls (e.g., longer than 10 minutes) to gather collateral data, update other individuals about the patient's treatment, or for other purposes may be charged for at my discretion.

CONFIDENTIALITY ISSUES WITH EMAIL: Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____.

I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is _____.

I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

SPECIAL ISSUES WITH CHILDREN AND ADOLESCENTS:

MEETINGS WITH PARENTS/CARETAKERS: In order to provide children and adolescents with the best possible psychiatric care, it is imperative that parents/caretakers be involved in the treatment. To that end, I may request that parents, either individually or separately, meet with me on a regular basis in order for them to apprise me of their assessment of their child's clinical condition/response to treatment and for me to assist them in implementing a comprehensive psychiatric diagnostic and treatment plan. These meetings will generally only be requested of parents/caretakers of psychotherapy patients, though other parents/caretakers are free to schedule time to meet with me as well.

In general, I expect to meet with parents/caretakers of children (i.e., under age 12) two times a month for 15-30 minutes and with parents/caretakers of adolescents (i.e., age 12-19) one time a month for 15-30 minutes. These meetings will be charged for at the aforementioned rates. Although these meetings can be conducted over the phone or during the child's scheduled psychotherapy time, this is not ideal for obvious reasons.

CONFIDENTIALITY ISSUES: Patient confidentiality is not absolute (e.g., imminent self-harm or danger to others, suspected child or elder abuse, court order to release information). This is especially true in the treatment of children and adolescents. Quite understandably, many parents/caretakers want to know what transpired in psychotherapy or medication management sessions. However, some degree of confidentiality is essential in order to develop a therapeutic alliance with patients (particularly adolescents). This alliance subsequently improves the quality of their psychiatric care.

Therefore, I will use my clinical judgment in deciding whether and when to relay information to parents that has been revealed to me by patients. In most cases, if I feel information needs to be communicated to parents, I will encourage the patient to do it themself. In clinically urgent or emergent situations, I may relay the information to parents myself.

Your signature below confirms that you have read, understand, and agree to the foregoing "Consent for Evaluation and Treatment."

SIGNATURE: _____ DATE: _____

10850 Wilshire Boulevard, Suite 850, Los Angeles, CA 90024
phone (310) 470-7064 fax (310) 470-7141 email chthompson@mednet.ucla.edu