Practice Information and Privacy Disclosure Statement

This document explains the policies and conditions of my practice. Please read it carefully and keep a copy of for your records. Please discuss any questions or concerns with me prior to signing the document. Effective date: March 28, 2018.

Description of Practice
I am a psychiatrist, which means that I completed medical school and a five year psychiatric residency at an accredited hospital. I provide psychotherapy and medication treatment for children, adolescents and adults. My approach to psychotherapy is broad. I will collaborate with you to determine a course and duration of treatment that is tailored to your needs.

Education, Training and Licensure
I have completed the following degrees and training: Bachelor of Arts, Yale University; Medical Degree, Harvard Medical School; psychiatric residency and fellowship, University of California. I am board certified in both general psychiatry and in child and adolescent psychiatry. My Washington medical license number is MD60229798.

Information for In-Network Clients: Premera, Regence, and most Blue Cross/Blue Shield* Plans
Your co-pay and other outstanding balances are due upon receipt of your monthly statement. If you would like me to submit claims on your behalf, I will use a third-party biller. Submission of claims to your insurance company does not guarantee payment. Certain services provided in this practice may not be covered by your insurance plan. You may also have an unmet deductible that results in higher than anticipated statement balances. You are responsible for any statement balance that is not paid by your insurance plan. You are responsible for understanding the specifics of your insurance plan.

*Please note: although I am a preferred provider for most Blue Cross/Blue Shield plans, these plans can be variable in regards to mental health benefits and in-network providers. Please call your insurance carrier to confirm that I am listed as an in-network provider.

Information for Out-of-Network and Self-Pay Clients
Payment is due in full at the end of each visit. Please be aware that most insurance plans only provide partial reimbursement for out-of-network services. Some plans will not cover out-of-network services until a very high deductible has been met, or will significantly limit the quantity and type of reimbursable services. You are responsible for any statement balance. You are responsible for understanding the specifics of your insurance plan.

General Fee Schedule

Initial Consultation	$445
Psychotherapy	$195-225
Psychiatric Evaluation/Management (fee based on complexity)	$175-215

Services provided outside of the usual appointment time, including telephone conversations lasting longer than 10 minutes, preparation of documents, preparation for/attendance at legal proceedings, or extensive interactions with insurance companies will be billed at a pro-rate of $240 per hour. Payment may be made with cash or check. There will be a $35 charge for returned checks. Accounts past due over 90 days will be referred to a collection agency.

The undersigned is responsible for payment of all fees. Responsibility for payment cannot be assigned to another person, such as another parent or guardian.

I,_____, understand and agree to the above policies and procedures.

Client/Parent/Guarantor Signature: _____Date_____

Nick Weiss, M.D.
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Missed Appointment Policy
Appointments canceled or missed with less than 48 hours notice will be billed at $150. Note that insurance will not reimburse for this fee and it will be billed to you directly.

Confidentiality
Your confidentiality as a patient is protected by state and federal law and by the ethics code of the medical profession. I will not release information about you or your treatment without your written permission. Under the following circumstances, the law authorizes and/or requires disclosure of protected health information: suspected abuse of a child, developmentally disabled person, elder or other dependent adult; imminent or planned harm to yourself or others; as otherwise required by a court of law (*see HIPAA disclosure document*). If you choose to use your insurance for our visits, I will be required to disclose information regarding the patient's diagnosis and treatment plan to the insurance company. I will also need to disclose information about the patient's diagnosis to my third-party biller.

Phone Calls and Emergencies
I generally return routine calls left on my office voicemail within one business day. For more urgent matters, I respond as quickly as possible. I only check messages between 9 AM and 7 PM. If you leave a message after 7 PM, I will respond the following day at the earliest.

If there is a life-threatening emergency or you are unable to wait for my return call, please call 911 or go to the nearest emergency room. You may also call the King County Crisis Line at (206) 461-3222. When I am not available, another clinician may be covering for me. In this event my voicemail will provide instructions for contacting the covering clinician.

Client's Rights
You have the right to be an active participant in decisions regarding your evaluation and treatment. You have the right to refuse evaluation or treatment, the right to choose the mental health provider and practice modality that best suits your needs, and the right to receive a referral from me to another mental health provider. You have the right to contact the Washington Department of Health at the below address to register a complaint or to obtain a copy of any acts of unprofessional conduct listed under RCW 18.130.180.

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4700 or (360) 236-2706

Authorization:

By signing below, you attest to the following:

I,_____, acknowledge that I have received a written report of the above office policies and notice of privacy practices. I understand and agree to the above policies and procedures. I acknowledge that I am responsible for all balances on my account or the account of my child. I have also received or declined a copy of the HIPAA disclosure document (separate).

Client/Parent/Guarantor Signature: _____Date_____