BRUCE ELIASHOF, MD
Psychiatry
Psychotherapy & Clinical Hypnosis

BruceEliashofMD.com
bruce@bruceeliashofmd.com 650.231.2042

OFFICE POLICIES

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Payments and Billing

As a patient of mine you are responsible for payments for my professional services. Payments are due at the time of the service. You may pay the fee at the time of your session in cash or by check. If you would like a billing statement, or receipt, for tax purposes or insurance reimbursements, I can provide you with one. The statement will include all necessary information. (Patient initials.) _____

Medical Insurance

I am not a contracted provider for any health insurance carrier. If you are a member of an HMO insurance plan, your insurance company will not reimburse you for any service I provide. If you are a member of a PPO insurance plan, your insurance company may reimburse you for a portion of my fees. This amount varies from plan to plan. I can provide you with the necessary information to obtain reimbursement, but any reimbursement to which you are entitled is a matter between you and your insurance company. (Patient initials.) _____

Missed Appointments and Late Cancellations

You will be charged the full fee for any appointments you schedule and do not complete, unless you provide me with 48 hours notice that you are canceling your appointment. If you provide me with less than 48 hours notice and I am able to fill your appointment time with another patient you will not be charged. (Patient initials.) _____

Confidentiality

You will have complete confidentiality for all elements of treatment with me. I will not acknowledge that you have been to my office unless you specifically authorize me to do so. (Patient initials.) _____

Availability by phone

The phone number to reach me is 650.231.2042

If at any time during your treatment you feel you have a life-threatening emergency, you are instructed to call 911, or to go to your nearest emergency room. (Patient initials.) _____

I have read and I understand and agree to all aspects of Dr. Bruce Eliashof's office policies and procedures, including my responsibility to pay fees for his services, and his missed appointment and late cancellation policy.

Patient signature _____

Printed name _____

Date _____