Private Access Psychiatry

113 N San Vicente Blvd., Beverly Hills, CA 90211
Phone: 818-731-2100 | Fax: 208-277-3558 | Dr. Amy Edwards, MD

FINANCIAL POLICY AND FEE AGREEMENT

FEE SCHEDULE — OUT-OF-NETWORK

Confidential Consultation	**$750**
Comprehensive Psychiatric Intake	**$3000**
Follow-up Session	**$1500**
Year-Long Subscription Retainer	**Available upon request**

Payment is due in full at time of service. We accept all major credit cards, checks, and cash. Private Access Psychiatry is a **cash-pay clinic, out-of-network** with all insurance plans. No insurance claims are filed on your behalf.

Upon request, a detailed superbill will be provided for you to submit to your insurer for potential out-of-network reimbursement. Reimbursement is not guaranteed and is determined solely by your insurance plan.

Cancellation Policy: Appointments cancelled with less than **24-hour notice** or missed appointments will be charged **50% of the scheduled fee**. Late arrivals may result in shortened sessions billed at the full rate.

By signing below, I acknowledge I have read, understand, and agree to the financial policies above and accept full responsibility for payment.

PATIENT SIGNATURE _____ DATE _____

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NEW PATIENT INTAKE FORM — ADULT

CONFIDENTIAL — PLEASE PRINT CLEARLY

PATIENT LEGAL NAME

DATE OF BIRTH

PREFERRED NAME / PRONOUNS

AGE

ADDRESS

CITY

STATE

ZIP CODE

PHONE (CELL)

EMAIL ADDRESS

EMERGENCY CONTACT NAME

RELATIONSHIP

EMERGENCY CONTACT PHONE

PREFERRED CONTACT METHOD

REASON FOR SEEKING TREATMENT / CHIEF CONCERN

CURRENT PSYCHIATRIC MEDICATIONS & DOSAGES

CURRENT MEDICAL MEDICATIONS & SUPPLEMENTS

ALLERGIES (MEDICATION / OTHER) & REACTIONS

PAST PSYCHIATRIC HISTORY (HOSPITALIZATIONS, DIAGNOSES, PRIOR PROVIDERS)

SUBSTANCE USE HISTORY (ALCOHOL, CANNABIS, NICOTINE, OTHER)

MEDICAL HISTORY & CURRENT MEDICAL CONDITIONS

FAMILY PSYCHIATRIC & MEDICAL HISTORY

I certify that the information provided is true and accurate to the best of my knowledge. I understand that withholding information may affect my care. I consent to psychiatric evaluation and treatment by Dr. Amy Edwards, MD.

PATIENT SIGNATURE

DATE

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CONFIDENTIALITY / NONDISCLOSURE AGREEMENT

ON LETTERHEAD — PRIVATE ACCESS PSYCHIATRY

I understand that all communications with Private Access Psychiatry and Dr. Amy Edwards, MD are confidential and protected under **HIPAA**, California law, and professional ethical standards. Information regarding my care will not be disclosed without my written authorization except as required or permitted by law.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

1. **No Recording Without Consent.** I agree not to make any audio, video, or photographic recordings of sessions, communications, or the office premises without prior express written consent from Dr. Edwards. This protects the privacy of all patients.
2. **Confidentiality of Other Patients.** I understand that I may encounter other patients in the waiting area or building. I agree not to disclose the identity, presence, or any information about other individuals receiving care at this practice.
3. **Protected Health Information.** I understand that my Protected Health Information (PHI) will not be shared without my written authorization, except as required by law, including but not limited to situations involving: imminent risk of harm to self or others, suspected child or elder/dependent adult abuse, or a valid court order/subpoena. I will be notified of any such disclosures when permitted by law.

This practice utilizes private, HIPAA-compliant communication systems. Please do not share confidential medical information via unsecured email or social media. Office correspondence is intended solely for the intended recipient.

By signing below, I acknowledge that I have read, understand, and agree to abide by the confidentiality and nondisclosure terms outlined above.

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TREATMENT AGREEMENT

COLLABORATIVE CARE EXPECTATIONS

In order to provide the highest quality psychiatric care, Private Access Psychiatry operates on a concierge, collaborative model. By engaging in treatment, we agree to the following mutual expectations:

1. **Appointment Attendance.** I agree to attend scheduled appointments and to provide at least 24-hour notice for cancellations or rescheduling. I understand that repeated late cancellations or no-shows may result in termination of the treatment relationship.
2. **Medication Adherence.** I agree to take prescribed medications as directed, to inform Dr. Edwards of any side effects, changes in medical condition, or use of other substances, and not to share medications or adjust dosages without discussion.
3. **Active Participation.** I agree to participate actively in my treatment plan, including providing accurate history, completing requested forms, and engaging in recommended follow-up.
4. **Respectful Communication.** I agree to communicate respectfully with Dr. Edwards and staff, during office hours and via agreed-upon messaging portals. Threatening, harassing, or abusive behavior will not be tolerated.
5. **Termination Policy.** I understand that the treatment relationship may be terminated for non-compliance with treatment recommendations, threatening behavior, or non-payment of fees. In such cases, appropriate referrals and a 30-day emergency coverage period will be provided when clinically appropriate.

I have read and understand this Treatment Agreement. I consent to treatment under the terms described and understand that I may ask questions at any time.

PATIENT SIGNATURE _____ DATE _____

> *Note: Emotional Support Animal (ESA) letters are evaluated separately per California AB 468. ESA documentation requires an established 30-day clinical relationship and independent clinical justification; such letters are not guaranteed and are not included in standard intake.*