ARSHIA ALEC SHIRZADI, D.O., INC
A PROFESSIONAL CORPORATION

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HARVARD TRAINED
BOARD CERTIFIED

ADULT PSYCHIATRY
PSYCHOPHARMACOLOGY

TREATMENT CONSENT FORM

This form letter is to answer some of the questions that may arise prior to our first visit. In preparation for our meeting please take a few minutes to read, sign and bring this form with you to our first visit.

SERVICES PROVIDED:

My approach is to first make an accurate diagnosis. I will then base treatment according to current treatment guidelines and adapt it to your unique and individual needs. Diagnosis will be made by gathering information from you about your symptoms and understanding them in the context of your life. At times, if needed, I will need to gather further information from other collateral sources, and use diagnostic scales to arrive at a working diagnosis. Much of this will be attempted at our extended initial meeting. The extended visit will allow time for me to gather information, possibly use diagnostic scales, and arrive at a working diagnosis and a treatment plan. You will then also have time to ask questions and discuss the working diagnosis and the treatment plan.

Psychiatric treatment may involve use of medication, talk therapy or combination of both. In certain situations, combination therapy may be more effective than medication therapy or talk therapy alone. This approach does not apply to every person at a given time, so I will thoroughly discuss all options with you, including what specific types of medication therapy or talk therapy I think will be more appropriate for your individual needs.

FREQUENCY AND DURATION OF VISITS

The first appointment which can be 45-55 minutes long is for an ***initial consultation*** – where we meet in person and discuss your psychiatric needs and concerns. More importantly, it is when we will decide if it is in our shared best interest to work together. There may be circumstances when I will not be able to assume care as your physician due to variety of reasons. At the end of our initial consultation, we will make the decision whether to begin a physician/patient relationship. If I am unable to accept your case, I will discuss this with you at that time.

In general if you are started on a new medication I would like to conduct a 20 - minute follow up with you in two weeks to assess adherence, efficacy, tolerance and any possible side effects that you may be experiencing. I will answer all other questions you may have with regards to the medication. Once your condition has improved, we may conduct 20 - minute follow up sessions every 4-8 weeks.

SESSION FEES AND CHARGES

Initial Evaluation "45-55 Minutes":	$225.00
Follow up visit "20- minutes": Medication management only:	$110.00
Follow up visit "50- minutes": Psychotherapy and/or medication management:	$200.00

All fees are due and are to be paid in full at the time of your appointment.
Payments maybe made in form of check, cash, or cashier's check. All checks or cashier's checks are to be made out to ARSHIA SHIRZADI, D.O.

During ongoing treatment there is no charge for phone calls less than five minutes long. Telephone calls longer than five minutes are charged at the rate of $25.00 per 10 minutes or any part thereof. Other miscellaneous services such as filling forms, letters, prior authorizations, telephone correspondence are billed at $45.00 per each 10 minute interval.

INSURANCE AND REIMBURSEMENT

I am not a provider for any managed care plans and do not participate in any HMO or PPO plans. You will be responsible for the full session fees at the time of your visit. I will provide you with a receipt of your payment known as the "superbill" which you can submit directly to your insurance company. Depending on your health insurance provider and your coverage, you may be reimbursed fully, partially or not at all by your provider. Since you will be responsible for the full session fees, therefore, I strongly urge you to call your insurance provider in advance and inquire about possible reimbursement.

CANCELLATION AND NO SHOW POLICY

There is a charge for appointments missed, rescheduled, or canceled less than twenty four (24) hours in advance. This charge is equal to the fee of the scheduled appointment, including the initial consultation. Your insurance provider will not cover cost of no shows, cancellations or missed appointments; therefore, you will be directly responsible for those charges.

CONTACT INFORMATION

In the event you need to reach me, simply call the office telephone number provided and leave a message on my voicemail. All non-urgent calls received before 5:00 PM Monday through Friday will be returned after office hours the same day. Non-urgent messages left on my voicemail after these hours will not be returned until after 5:00 PM the following business day. Messages left after 5:00 PM on Friday will be picked up on Monday and returned after 5:00 PM the same day. If there is a medical or psychiatric emergency, you must call 9-1-1 or go to the nearest hospital. If it is an urgent matter which requires my immediate attention and can not wait for the call back at the end of business day/next business day, please call the office number provided and follow the instructions. Always leave your full name and the phone number where you can be reached. The telephone number you provide must accept calls from a blocked a number; otherwise I may not be able to reach you.

You can also reach me for all none clinical and none urgent matters via email. The email account is not a secure way to communicate sensitive health information. You are to only use it for none clinical matters. You are not to use the email for any matters that may need my immediate attention.

My commitment is to provide you with the highest quality care possible. Should you have any questions that you feel you must ask me prior to our initial meeting, please don't hesitate to call me. A professional relationship of mutual trust and respect is and integral part of our work together.

Sincerely,

Arshia Alec Shirzadi, D.O.

I have read this letter in its entirety and agree to all the terms and conditions herein.

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| Print your first and last name | Signature | Date |