Sayeh Beheshti, M.D., M.A.
18141 Beach Blvd., Suite 220
Huntington Beach, CA 92648

Phone: (714) 274-9848
Fax: (714) 274-9855
Email: DrB@DoctorBeheshti.com
Website: DoctorBeheshti.com

OFFICE POLICIES, PROCEDURES, AND DISCLOSURE STATEMENT

CONFIDENTIALITY

I understand that all information between myself and Dr. Beheshti is held strictly confidential and no information about my psychiatric and psychological services including diagnosis, treatment, prognosis, progress or any other confidential information will be released unless permitted by law or:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/Elder abuse or neglect is suspected,
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As necessary for continuity of care,
7. I fail to make regular payments on my outstanding bill which could result in information being forwarded to a collection agency.

I understand that in cases 2, 3 and 4, Dr. Beheshti is required by law to inform potential victims and legal authorities so that protective measures can be taken. This clinic follows the "minimum necessary" rule for release.

PLEASE INITIAL

RELEASE OF INFORMATION & KEEPING HEALTH INFORMATION CURRENT

In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other health care providers and facilities for purposes of diagnosis and treatment. It is my responsibility to keep my doctor informed of changes to my health that can affect treatment.
(Release of information to providers, family, etc., requires a separate form.)

PLEASE INITIAL

GRIEVANCES

I acknowledge that I may submit a grievance to Dr. Beheshti at any time to register a complaint about any aspect of my care.
NOTICE TO CONSUMERS- Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

PLEASE INITIAL

GENERAL CONSENT FOR TREATMENT

I voluntarily authorize and request Dr. Beheshti to carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand thatthe purpose of these procedures will be explained to me upon my request and subject to my agreement.
I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that Dr. Beheshti will keep a clinical record that will contain information regarding my diagnosis, treatment, prognosis, progress, and other documents pertinent to my treatment. This record is confidential and will only be released with my written consent except in cases detailed under "Confidentiality."

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EMERGENCY PROCEDURES

I understand that my provider may not be available for emergencies due to clinic or other responsibilities. If an emergency or life threatening situation arises, I will follow the emergency procedures as follows: I will call 911 or go to my nearest Emergency Room or call a telephone Crisis Line at 1-800-273-TALK. For urgent situations or distress, such as medication side effects, I will call Dr. Beheshti and leave a message. I understand that calls will be returned periodically through the day and I will call again if I do not receive a response within 24 hrs. If my call is not promptly returned and I require immediate attention, I will follow the above emergency procedures.

PLEASE INITIAL

FINANCIAL TERMS

I understand that Dr. Beheshti is not on any insurance panels and that I am responsible for payment in full at each appointment. I also understand that Dr. Beheshti will provide me with a superbill for each visit indicating the services provided and that I may submit this to my insurance plan for consideration of partial reimbursement. Accepted methods of payments include cash, checks, or credit card (Visa, Mastercard, Discover, American Express). I will make checks payable to "Doctor Beheshti, M.D., Inc." I understand that the charge for a bounced check is $20 in addition to the fee for service.

SERVICES AND FEES:

Initial Evaluation - 50 minutes	$450	Medication Management - 50 minutes	$450	Psychotherapy - 110 minutes	$700
Initial Detailed Evaluation - 80 minutes	$675	Psychotherapy - 50 minutes	$450		
Medication Management - 25 minutes	$250	Psychotherapy - 80 minutes	$675		

PLEASE INITIAL

FEES FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS:

I will do my best to be on time for appointments. My appointment time is reserved for me to meet with Dr. Beheshti. If I am more than 15 minutes late, I have missed my appointment and need to reschedule in order for my provider to deliver safe and effective care to me and subsequent patients on that day. I understand there is a 24-hour cancellation policy and that I will be billed in full for missed appointments. I understand Dr. Beheshti has very limited availability and early notification allows other patients to utilize that time.

PLEASE INITIAL

REQUEST FOR RELEASE OF RECORDS

If I sign to request my records to be released, I understand that these records may be released in the form of a summary. I understand I will need to meet with my provider to discuss information that will be released.

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PRESCRIPTIONS & REFILL REQUESTS:

If I am receiving prescribed medication, it is imperative that I attend regular follow up visits for Dr. Beheshti to monitor my progress and potential side effects. I will contact my doctor with any concerns or questions requiring immediate attention. Self-discontinuation of medications can result in consequences my doctor may be unaware of and put me at risk. In general, medication refills will only be given at appointments. In special circumstances or if I need to reschedule my appointment, I may receive a refill to last me until my next scheduled appointment. I will have my pharmacy make a request 5-7 days before my medication runs out.

PLEASE INITIAL

HOW TO MAKE THE MOST OUT OF MY CARE

Dr Beheshti values patient education and emphasizes this in her practice. I am encouraged to ask questions and to take an active role in my education, care, and decision making process. I will be educated on the signs and symptoms of my diagnosis, treatment options, and the indications, benefits, and risks in order to help me choose the treatment that is most beneficial and best suited to me. Although every attempt will be made to ensure that all my questions are answered, time constraints and volume of information make it difficult to provide an "all inclusive" education. I will thus be offered resources for self-directed learning and encouraged to make lists of issues I wish to address at appointments. It is understood I am engaging in treatment as an outpatient and therefore am consenting to utilize Dr. Beheshti's services by showing up at appointments. If recommended, and I choose to take medication as part of my treatment, consent is verified when I actively acknowledge a prescription and take the medication on my free-choice.

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Withholding information from my doctor can increase risk for complications, life threatening interactions, and prolonged course of illness. I understand that if I would like to make changes to my treatment between appointments, I need to come into the office and be seen in person. I further agree that it is my responsibility to call to schedule said appointment. I am aware that Dr. Beheshti may be available by phone in matters of immediate concern, however, in order to provide the highest quality of care, no treatment will be discussed at length over the phone or email. I will make every attempt to be present for my scheduled appointments. I understand that a returned phone call by my provider does not take the place of a session and I may be required to schedule a follow up appointment for safe and effective management of my condition.

PLEASE INITIAL

I understand that Dr. Beheshti has the right to refuse to continue as my healthcare provider if my care is being compromised by treatment non-adherence, lack of follow up, engaging in behaviors or other issues which are detrimental to my health and treatment. I will be notified of necessary changes if something like this should occur and will be offered referrals to other providers if I am unable to adhere to the guidelines of the recommended course of treatment. Abuse of any of the medications or services provided can result in termination of care.

PLEASE INITIAL

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE AND HAVE BEEN GIVEN A COPY FOR MY RECORDS.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____