Shahla Modir, M.D.
Psychiatrist
13323 W. Washington Blvd. Suite 202
Los Angeles, CA 90066
(310) 896-6915 Fax (310)279-5019

Date _____

Contact Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: Home _____ Cell: _____

Email: _____ Date of Birth: _____ Age: _____

Marital Status: S M P D W Number of Children: _____

Occupation: _____

Emergency contact: _____
Phone number: _____

Reason for Visit: _____

_____

_____

_____

Drug Allergies: _____

Past Medical History: _____

_____

_____

Current Medications: _____

_____

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OFFICE POLICIES

General Policies

1. All patients must fill out the patient info form and 24-hour cancellation form.
2. All patients must be in good standing to receive ongoing pharmacologic support
3. Patients on maintenance medication must been seen a minimum of one time every 3 months if completely stable in the judgment of Dr. Modir.
4. Patients who are less stable will be required to be seen more frequently as determined by Dr. Modir.
5. Patients will be prescribed adequate quantities of medication sufficient to maintain them in between visits
6. In an event that a patient is not able to be present for a follow up visit at the appropriate interval they will be given an "extension prescription period:, for a minimum of 2 days and a maximum of 1 month
7. If the patient is not able to return at the end of the "extension period", the patient is not entitled to further extension of prescriptions until they come in for a session
8. Patients will have to have financial accounts in good standing in order to be eligible to schedule further appointments.
9. Dr. Shahla Modir's cancellation policy will be strictly enforced. See Below,

Late Policy

If a patient is late for an appointment, the doctor can only see that patient for the amount of time that is left of patient's session.

Chronic lateness will not be tolerated, and the patient may be asked to seek treatment elsewhere.

Cancellation Policy

There is a 1-business day (Mon-Fri) cancellation policy. Patients must cancel more then 24 hours in advance or be subject to a cancellation charge.

- If a patient cancels within less then 24 hours or "no shows" for an initial comprehensive assessment, they will be charged 100% of the visit price before additional scheduling of appointments, which is $400.
- If a patient cancels within less then 24 hours or "no shows" for another type of visit, they are charges the cost of the scheduled visit, or $200 which is the minimum visit price.
- The charge will be applied to the credit card if one is on file, otherwise the patient will be billed.

Initials: Patient, Representative or Financially Responsible Person: _____

Code of Conduct

1. I agree to keep, and to be timely for all my scheduled appointments with the doctor and staff. If needed, I must cancel my appointment within 24 hours to avoid a fee.
2. I agree to conduct myself in a courteous manner in the office. Any verbal or physical aggression may result in a clinical decision to dismiss you from treatment with referrals to alternate appropriate levels of care.
3. I agree not to arrive at the office under the influence of drugs/ and or alcohol. If I do, the doctor may choose not to see me and if I am seeing the doctor for medication management, I will not be given any medication until my next scheduled appointment. If driving, I may be asked to obtain alternate means of transportation in order to leave the premises. (This should say will take your keys away and call you a cab or a friend/relative to pick you up).

Initials: Patient, Representative or Financially Responsible Person: _____

I have read and agree to the above clinical policies and patient responsibilities

Date: _____ **Time: _____**

Signature: _____

Print Name: _____
(patient or personal representative0
If signed by other then patient, Indicate relationship_____

Witness: _____

Print Name: _____

Limits of Confidentiality
All information between Shahla Modir, M.D. and patient is held strictly confidential. There are legal exceptions to this:
1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v. County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v. Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.
All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency.

Release of Information
I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information including diagnosis for pharmacy prior certification, claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Emergency Access:
Shahla Modir, M.D. or another covering psychiatrist is available after hours to handle emergencies. By calling (310) 896-6915 during after hours, you will be instructed how to contact the on-call psychiatrist.

Consent for Treatment
I authorize and request Shahla Modir, M.D. to carry out psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that that while the course of my treatment is designed to be helpful, Shahla Modir, M.D. can make no guarantees about the outcome of my treatment. Further, the evaluation process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger.

Patient/Guardian Signature _____ Date _____

SHAHLA MODIR, M.D.
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

NAME: _____ DOB: _____

I have been provided a copy of the Notice of Privacy Practices for Shahla Modir, M.D. with an effective date of July 20, 2003.
If I have any questions regarding the Notice or my privacy rights, I can contact Shahla Modir, M.D. 13323 W. Washington Blvd. Suite 202 Los Angeles, CA 90066. 310-896-6915

_____
Signature of Patient, Parent, Guardian or Personal Representative Date _____
If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).
HIPAA NOTICE: 10.01.09
Patient Name_____ Phone #_____
Email:_____