

Sina Safahieh, M.D.
Child, Adolescent and Adult Psychiatry

3620 Birch St. Suite 210
Newport Beach, CA 92660

Phone/Fax/SMS: 949-207-6775
sina@psychiatryOC.com

www.psychiatryOC.com

Office Policies

In order to prevent any misunderstanding concerning your psychiatric care, including contact in between sessions, cancellation policy, responsibility for payment for services provided, please read the following information carefully:

EVALUATION AND TREATMENT

First we need to clarify what the problems are and what treatment would be best for you. After the initial assessment, we will discuss the risks and benefits of treatment options, which may include therapy or medication treatment, or a combination of both. If you feel it is not possible for us to work together for any reason, I will do my best to refer you to other mental health clinicians better suited for your needs.

FEES

Initial Evaluation – 60 to 90 minutes: \$600.00

Follow-up Sessions (With or without medication): 50 minutes: \$500 25-30 minutes: \$250.00

PAYMENTS

Payment for services provided is due at the end of each session (cash, check, credit/debit cards). If your account has payment overdue for over 60 days, legal means will be considered to secure payment, including collection agencies or small claims court. There will be a \$25.00 service charge for all returned checks.

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to pay for it unless you provide at least **24 business hours** advance notice of cancellation. If you do not provide at least 24 business hours notice, or fail to show for a scheduled appointment, you will be responsible for the **full** cost of the session. Insurance companies will often not reimburse for missed sessions or sessions cancelled late.

INSURANCE REIMBURSEMENT

I am considered an “out of network provider” for PPO plans. Please be aware that your health insurance policy is an agreement between you and your insurance company. All charges are your responsibility, whether or not you have insurance. I will provide you with a statement that can be submitted to your insurance company. Please find out from your insurance company exactly what mental health benefits are covered.

Initials _____

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CONTACTING ME

All calls to my office number are answered by voice mail. I do check for messages frequently throughout the day, even on weekends, and return phone calls by the next business day. You are welcome to email or text me, but I do not check for messages as regularly as I do with voicemail messages, and therefore, I cannot guarantee that I will respond to email or text messages in a timely manner. Please be aware that email is not a secure medium. Please contact me with questions or concerns about medication supply. If you missed or could not make an appointment, you will be given enough medication to last until our next rescheduled session, usually within 2 weeks.

Please call 911 or go directly to nearest emergency room in event of a psychiatric or medical emergency.

PATIENT RECORDS

Both the law and the standards of my profession require that I keep appropriate treatment records. You are entitled to review a copy of the records, unless I believe seeing them would be emotionally damaging, in which case, I will be happy to provide them to an appropriate mental health professional of your choice. Because these are professional records, they can be misinterpreted or upsetting, so I recommend that we review them together so that we can discuss what they contain. I can also prepare an appropriate summary for review.

CONFIDENTIALITY

Confidentiality is of utmost importance in mental health treatment and is protected by the law. I can only release information about our work to others with your written permission. For child and adolescent patients, their trust in me is paramount. Before discussing a sensitive issue with the parent I will first get the minor's permission. I generally try to help the child/adolescent to discuss any sensitive matters with their parents themselves.

There are exceptions to confidentiality where disclosure is required by law. These are:

- Threat of harm to self
- Threat of harm to others
- Inability to care for your basic needs (food, clothing, shelter)
- Indication of possible abuse to a child, elderly person, to disabled person

In the event of any of the above, I may have to contact other parties (ie. family members, state agency, police, or hospital) in order to protect you or someone else.

PRACTICE STATUS

I share an office suite with other mental health professionals. With regard to your clinical care, I am completely independent and solely responsible. My clinical records are separately and securely maintained.

I have read and understand all the information above. I agree to evaluation and/or treatment by Dr. Sina Safahieh, that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

Patient name: _____

Name of responsible party (if other than patient): _____

Signature of patient/responsible party: _____ Date: _____

PATIENT INFORMATION FORM

LAST	FIRST	MI	YYYY	MM	DD	<input type="checkbox"/> M <input type="checkbox"/> F
NAME			BIRTHDATE			GENDER

STREET
CITY, STATE
ADDRESS, ZIP CODE

SOCIAL SECURITY NUMBER

<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED	
RELATIONSHIP STATUS		

EMAIL <input type="checkbox"/>
HOME PHONE <input type="checkbox"/>
WORK <input type="checkbox"/>
CONTACT INFORMATION. PLEASE INDICATE PREFERRED METHOD OF CONTACT <input type="checkbox"/>

RELIGIOUS/SPIRITUAL BACKGROUND

HIGHEST LEVEL OF EDUCATION / DEGREE / SPECIALIZATION
--

NAMES AND AGES
CHILDREN (IF APPLICABLE)

OCCUPATION
NAME
OCCUPATION
SIGNIFICANT OTHER'S NAME & OCCUPATION (IF APPLICABLE)

NAME
PHONE
STREET ADDRESS
CITY, STATE
COUNTRY, ZIP CODE
PRIMARY CARE PHYSICIAN

1. NAME
PHONE
RELATIONSHIP
2. NAME
PHONE
RELATIONSHIP
EMERGENCY CONTACTS

SIGNATURE: _____ DATE: _____

HOW DID YOU HEAR ABOUT DR. SAFAHIEH?

PLEASE DESCRIBE THE REASON FOR SEEKING TREATMENT (INCLUDE DATE/MONTH THE PROBLEM BEGAN)

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST MONTH:

- | | |
|--|--|
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> NOT FINISHING PROJECTS |
| <input type="checkbox"/> DIFFICULTY STAYING ASLEEP | <input type="checkbox"/> EASILY DISTRACTED |
| <input type="checkbox"/> EARLY MORNING WAKENING | <input type="checkbox"/> HEARING VOICES |
| <input type="checkbox"/> DECREASED ENERGY/FATIGUE | <input type="checkbox"/> SEEING THINGS THAT ARE NOT THERE |
| <input type="checkbox"/> APPETITE CHANGE- INCREASED OR DECREASED | <input type="checkbox"/> FEELING PARANOID |
| <input type="checkbox"/> WEIGHT- LOSS OR GAIN | <input type="checkbox"/> OBSESSIVE THOUGHTS |
| <input type="checkbox"/> HOPELESSNESS/HELPLESSNESS | <input type="checkbox"/> COMPULSIVE BEHAVIORS |
| <input type="checkbox"/> LOSS OF INTEREST | <input type="checkbox"/> PERFECTIONISM |
| <input type="checkbox"/> SEXUAL DYSFUNCTION | <input type="checkbox"/> SOCIAL ANXIETY |
| <input type="checkbox"/> TEARFULNESS | <input type="checkbox"/> PERFORMANCE ANXIETY |
| <input type="checkbox"/> DEPRESSED MOOD | <input type="checkbox"/> SPECIFIC PHOBIA |
| <input type="checkbox"/> POOR CONCENTRATION | <input type="checkbox"/> AGORAPHOBIA |
| <input type="checkbox"/> MEMORY DIFFICULTIES- SHORT TERM | <input type="checkbox"/> NERVOUSNESS/ANXIETY |
| <input type="checkbox"/> MEMORY DIFFICULTIES- LONG TERM | <input type="checkbox"/> EXCESSIVE WORRY/FEAR |
| <input type="checkbox"/> TROUBLE ORGANIZING THOUGHTS | <input type="checkbox"/> PANIC ATTACKS |
| <input type="checkbox"/> FEELINGS OF GUILT | <input type="checkbox"/> HYPERVIGILANCE |
| <input type="checkbox"/> THOUGHTS OF HARMING YOURSELF | <input type="checkbox"/> FLASHBACKS OF TRAUMATIC EVENT |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> IMPULSE CONTROL PROBLEMS | <input type="checkbox"/> EATING DISORDER |
| <input type="checkbox"/> ANGER OUTBURSTS | <input type="checkbox"/> PREGNANCY RELATED MOOD DISORDER |
| <input type="checkbox"/> DECREASED NEED FOR SLEEP | <input type="checkbox"/> POSTPARTUM DEPRESSION |
| <input type="checkbox"/> RECKLESS BEHAVIOR | <input type="checkbox"/> POSTPARTUM PSYCHOSIS |
| <input type="checkbox"/> PROMISCUITY | <input type="checkbox"/> RELATIONSHIP DIFFICULTIES |
| <input type="checkbox"/> RACING THOUGHTS | <input type="checkbox"/> LEGAL TROUBLES |
| <input type="checkbox"/> HYPERACTIVITY | <input type="checkbox"/> THOUGHTS OF BRINGING HARM TO ANOTHER PERSON |
| <input type="checkbox"/> TALKING TOO FAST OR TOO MUCH | |

LIST OF MEDICAL CONDITIONS

LIST OF SURGICAL PROCEDURES

YYYY	MM	DD
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DATE OF LAST PHYSICAL EXAM

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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ALLERGIES

CURRENT MEDICATIONS (DOSE, FREQUENCY, PRESCRIBING MD)

VITAMINS/HERBS/SUPPLEMENTS

ALCOHOL

CIGARETTES

CAFFEINE

OTHER DRUGS (PLEASE LIST)

HOW MUCH OF THE FOLLOWING DO YOU CONSUME OR HAVE COMSUMED IN THE PAST

PREVIOUS PSYCHIATRIC DIAGNOSES/TREATMENT/MEDICATIONS

LIST OF PSYCHIATRIC ILLNESS IN ANY OF YOUR FAMILY MEMBERS

HAVE YOU EXPERIENCED ANY TRAUMA OR ABUSE (PHYSICAL, EMOTIONAL, SEXUAL, NEGLECT)

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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Acknowledgement of Receipt of HIPAA Document

I, _____, have received a copy of the Notice of Privacy Practices.
(Name of patient or guardian)

(Signature of patient or guardian) (Relationship to patient) (Date)

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CREDIT CARD AUTHORIZATION FORM

LAST	FIRST	MI
------	-------	----

PATIENT NAME

<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER

TYPE OF CARD

--	--	--	--

CREDIT CARD NUMBER

MM	YYYY	
----	------	--

EXPIRATION DATE

SECURITY CODE

--

CARD HOLDER NAME (EXACTLY AS APPEARS ON CREDIT CARD)

--

CARD HOLDER PHONE #

--

STREET ADDRESS

--

CITY, STATE

--

COUNTRY, ZIP CODE

--

CREDIT CARD BILLING ADDRESS

I AUTHORIZE SINA SAFAHIEH, M.D.; TO KEEP MY SIGNATURE ON FILE AND TO CHARGE MY CREDIT CARD FOR MISSED APPOINTMENTS AND ANY UNPAID BALANCES FOR SERVICES ALREADY RENDERED.

CARD HOLDER SIGNATURE: _____ DATE: _____

ALL CHARGES WILL APPEAR ON YOUR CREDIT CARD STATEMENT AS "SINA SAFAHIEH , M.D."