Adam Strassberg, M.D.
415 Cambridge Avenue, #7
Palo Alto, California 94306-1608
Office: 650-427-0779

Mobile: 650-776-9625
Fax: 888-959-7897
Web: www.doctorstrassberg.com
E-Mail: dr.strassberg@gmail.com

Consent to Treatment and Agreement to Pay for Professional Services

In exchange for psychiatric care and treatment from Adam Strassberg, M.D., I consent to the following terms and conditions:

1. **Scope of Treatment**: I assent voluntarily to receive psychiatric care and treatment. Treatment may include diagnostic evaluation, psychotherapy and/or medication. All treatments have attendant risks and benefits. I may terminate treatment at any time and, upon termination, I will be responsible only for full payment of services already received. Specific predictions and guarantees cannot be made regarding the length, course or outcomes of treatment. Dr. Strassberg may terminate our doctor-patient relationship at any time.

2. **Consent for Medication**: If medications are indicated for my treatment, Dr. Strassberg will advise me of the reasons for each medication, and also their benefits, risks, alternatives, and possible side-effects. Most patients experience few to no side-effects and most side-effects improve with time or a change in medication regimen or dosage. By taking any future prescribed medications I agree that:
   - I will have been informed of the nature of my condition, the reasons for taking medication, including the risks, benefits, likelihood of improvement, reasonable treatment alternatives, type of medication, dose ranges, frequency, estimated duration, and potential side effects.
   - I will have consented to take medication as prescribed and will have been informed that I can decline medication at any time.
   - I will have been informed that any information regarding medication(s) represents only a partial list of potential side effects.
   - I will agree to discuss with Dr. Strassberg any questions, concerns or side effects that may arise during medication treatment.
   - For women: I will notify Dr. Strassberg if I am or will be pregnant or breastfeeding.
   - I will agree to complete laboratory tests and/or EKGs as needed.
   - I will have been given an opportunity to ask questions regarding my medications, and all such questions will have been answered to my satisfaction.

3. **Financial Agreement:** If I am using my health insurances benefits, I agree to pay in full at time of service the co-payment, co-insurance and/or deductible for all professional services provided by Adam Strassberg, M.D. If I am not using my health insurance benefits, I agree to pay in full at time of service all professional services provided by Adam Strassberg, M.D. I understand that my doctor-patient relationship with Adam Strassberg, M.D. will terminate upon non-payment of any fees owed to him by me. Cash and check are accepted. Credit card and debit card are accepted, however a 2.83% processing fee will be applied. Paypal is accepted, however a 4.55% processing fee will be applied. A receipt can be provided upon request after each session. If I am using my health insurances benefits, Dr. Strassberg will bill my insurance provider directly. If my check is returned for insufficient funds, I will be charged an additional fee of $50.00.

4. **Cancellation policy and Missed Appointments**: Dr. Strassberg requires a minimum of 48 hours advance notice to cancel or reschedule any appointment. Missed appointments and those canceled and/or rescheduled within less than 48 hours notice will incur a $100.00 no-show fee. Make-up appointments will be offered as Dr. Strassberg's schedule allows. Two consecutive missed appointments will terminate my doctor-patient relationship with Dr. Strassberg.

5. **Confidentiality and Privacy Practices:** I acknowledge that I have reviewed the web pages entitled "Confidentiality in Therapy" and "HIPPA Notice of Privacy Practices for Protected Healthcare Information". The general content of these two web pages has been summarized for me by Dr. Strassberg, who also has offered me paper copies of these documents at our first meeting.

6. **Release of Information:** If I am using my health insurance benefits, to an extent necessary, Dr. Strassberg must disclose portions of my financial or medical record in my bill or account statement to the third party of my health insurance company (typically the date of service, the services rendered, and a diagnostic code must be provided). Dr. Strassberg will obtain my verbal consent and/or written authorization to release further information – other than basic information – except in those circumstances where release of information is permitted or required of him by law. With my written authorization, Dr. Strassberg may also discuss, exchange or release information to my referring health care providers to ensure my continuity of care. Also, if I am hospitalized involuntarily due to a mental condition, I hereby give my consent for Dr. Strassberg to forward appropriate written records to hospital staff to assist them in my care and treatment and to discuss directly my case with hospital staff.

7. **Letters and Forms:** Upon patient request and via mutual agreement, Dr. Strassberg is able to write brief letters and/or complete various forms unrelated to direct clinical care. There is a charge of $50.00 per distinct letter written and/or form completed in this regard. Dr. Strassberg will not complete any forms or letters related to short-term or long-term disability claims. Dr. Strassberg will not complete any forms or letters related to academic or job accommodations.

I consent to treatment with Adam Strassberg, M.D. and agree to pay for his professional services under the above rates and terms. I have read this form, I have been informed of the contents herein, I agree to all terms and provisions herein, I agree to pay in full for all services rendered. I understand that non-payment of fees and/or violation of terms and provisions above will terminate my doctor-patient relationship with Adam Strassberg, M.D. I acknowledge my understanding and review of the web pages and/or documents describing "Confidentiality" and "HIPPA Notice of Privacy Practices for Protected Healthcare Information". I have been given an opportunity to ask questions, and I have had all such questions answered to my satisfaction.

DATE: _____ PATIENT SIGNATURE:_____

To be completed by Dr. Strassberg:
I have discussed the various issues addressed in the web pages and/or documents "Confidentiality in Therapy", "HIPPA Notice of Privacy Practices for Protected Healthcare Information", and "Consent to Treatment and Agreement to Pay for Professional Services" with the above person. My observations of the behavior and responses of the above person give me reason to believe that the above person has the capacity to give informed and voluntary consent for treatment including medications and payment.

DATE:_____ Adam Strassberg, M.D. _____