Arman Taghizadeh, M.D.
2324 West Joppa Road, Suite 220
Lutherville, MD 21093

Patient Name: ______________________________________ DOB: ______________
Legal Guardian/Parent: ____
Street Address: ____
City, State, Zip: ____
Home Phone: ____
Cell Phone: ____
Work Phone:_ ____
Email Address: ____
Referred by: ____

Primary Care Physician (Name, Address, Phone, Fax):_________________________
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RESPONSIBLE PARTY: Who is Responsible for the account?
Name: _______________________
Relationship to Patient: ____________________________
Address: ____
Phone number(s):____

FINANCIAL POLICIES

Cancellation Policy: If you do not plan to keep your initial appointment, you must notify us no less that 72 hours (business days) in advance or there will be a $300 charge. If you fail to show up for the appointment, you will be charged the full amount. Follow up appointments require 48 hours notice or you will be charged the full amount.

All fees (cash/check) are due at the time services are rendered.

CONSENT TO TREATMENT

With my signature below, I give permission and consent to Arman Taghizadeh, M.D. to provide psychiatric services, which may include an initial evaluation, consultation with myself, members of my family or other providers (with expressed written or verbal consent), psychotherapy (individual, family) and/or medication treatment. This consent will apply to me and to my child for whom I have legal custody and power of consent for medical treatment. I will be solely responsible for charges occurred during treatment with Dr. Taghizadeh since Dr. Taghizadeh will not seek payment from my insurance company or HMO.

Signature: ____ Date: __________________