Anita Red, MD
Adult, Adolescent, & Child Psychiatrists

The Office of Dr. Anita Red and Dr. Mustafa Rehmani

Informed Consent for Psychiatric Treatment

Patient Name: _____
Date of Birth: _____

Phone Number: _____

Email: _____

Adress: _____
Provider: _____

Purpose of Treatment

I understand that I am seeking psychiatric evaluation and/or treatment, which may include psychotherapy, medication management, or other clinically appropriate services.

Patient initial: _____

Nature of Treatment

I understand that:
- Psychiatric treatment involves discussing my emotional, behavioral, and physical health.
- Treatment may include psychiatric medications, which have potential benefits, risks and side effects.
- I have the right to ask questions about my treatment at any time.

Patient initial: _____

Risks and Benefits

I acknowledge that:
- Treatment may lead to improvement in mental health symptoms.
- There are no guarantees about results.
- Possible risks include emotional discomfort, medication side effects, or unforeseen reactions.

Patient initial: _____

Voluntary Participation

I understand that participation in treatment is voluntary. I may withdraw consent at any time, except where safety concerns require continued assessment.

Patient initial: _____

Emergency Situations

I understand that in the event of a psychiatric emergency, I should call 911 or go to the nearest emergency room.

Patient initial: _____

Consent

I hereby consent to psychiatric evaluation and treatment.

Patient Signature: _____ Date: _____

Telehealth Consent (California-Compliant)

Description of Telehealth

I understand that telehealth involves the use of electronic communications (video, audio, or text) for psychiatric evaluation and treatment.

Patient initial: _____

Risks and Limitations

I understand that telehealth:

- May experience technical issues, including interruptions or unauthorized access.
- Does not guarantee the same level of privacy as in-person visits.
- Cannot be used during emergencies.

Patient initial: _____

Patient Rights

I understand that I have the right to:
- Refuse telehealth and request in-person care (if available).
- Ask questions about telehealth procedures.

Patient initial: _____

Confidentiality

Telehealth sessions will be conducted in accordance with HIPAA and California privacy laws.

Patient initial: _____

Consent

I consent to receiving psychiatric services via telehealth.

Patient Signature: _____ Date: _____