Shikha Verma, M.D. DFAACAP
Distinguished Fellow of American Academy of Child and Adolescent Psychiatry
Fellow of American Psychiatric Association.
Diplomate of the American Board of Psychiatry and Neurology in General and Child and Adolescent Psychiatrist
Diplomate of the American Board of Preventive Medicine, Addiction Medicine

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Office Policies and Consent to Treatment – Form B

I am pleased that you have chosen me to help. I look forward to the opportunity to work with you. Mental health issues are unique in that invaluable information is conveyed non-verbally through gestures and through inflection of speech. Therefore, I provide the highest quality of treatment through face-to-face contact and telemedicine. Most of the policies outlined in the following forms and summarized below are meant to encourage at least telemedicine or face-to-face contact. While these issues have been covered in the other forms, I have reiterated them here for emphasis and for clarity. Please review and sign below.

For established patients: If you have a clinical emergency and you need **immediate assistance, please call 911 or crisis/suicide hotline 988 or go to your nearest emergency room.** For non-urgent concerns or after hours, email us or you can leave a message on the office phone number. I will respond to you usually no later than 24-48 business hours. Running out of your medications and needing a refill is NOT considered an urgent or life-threatening matter. Please try to anticipate refills in a timely manner.

Patients are seen by appointment only.

Please provide at least 1 business day notification, from the time of your appointment, for cancellation to avoid a no-show fee. For example, to cancel the 0900am appointment on Monday, I need to know by 0900am Friday that you intend to cancel. The no show fee is equivalent to the cost of the appointment. Insurances do not reimburse for no show fees.
I check my voicemail and email/text on **weekdays** between regular business hours. To be clear, I do not check messages on the weekends or national

holidays. I will respond to messages within 24-48 business hours. Please note, if you leave a message on Friday, you may not receive a response until Monday.

Email and texting carry inherent risks (see your Email/Texting Consent Form for details). Email should be limited to brief logistical issues or facilitating the collection of background information, e.g. scheduling appointments, obtaining medication refills, and/or sending forms or past mental health evaluations. Current clinical matters that could be construed to request clinical advice should be called in by phone or discussed face-to-face in an appointment. **If you email/text clinical matters, e.g. your current mental status or problem, I will NOT provide advice by email/text. You will receive a phone call in 1-2 business days. Do not email/text life threatening matters: these should be called to 911 or crisis/ suicide hotline 988.**

Inappropriate use of email/texting will incur charges of at least 25$ and prorated based on time spent to address the issue at $600/hour for adults/ youth) at 5-minute increments.

All forms are charged at a base rate of $25. If they take longer than 5 minutes, they will be billed at $600/hour for adults/ youth, at 5-minute increments.

Consent to Evaluate/Treat

I voluntarily consent that I (or my child, whichever is applicable) will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by Shikha Verma, MD. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
e. Probable consequences of not receiving treatment

Evaluation and treatment may be administered with psychological interviews, psychotherapy, pharmacotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me (or my child), as well as the referring professional, to understand the nature and cause of any difficulties affecting my (or my child's) daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

I also understand that, while the purpose of treatment is designed to be helpful, risks are possible. These include side effects from medications. In addition, psychotherapy may be at times difficult and uncomfortable as emotionally laden topics are confronted and explored.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself (or of my child). If applicable, I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions from my child's service provider about the above information at any time.

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Signature of patient (or legal guardian for a minor under age 18) **Date**