Clinical Responsibilities

Doctor's Responsibilities

1. Provide psychiatric care which meets, if not surpasses, the standard of care in the community.
2. Provide 24-hour availability by phone for psychiatric emergencies.
3. Provide assessment of initial situation, ongoing re-evaluation, and diagnosis as requested.
4. Provide information about medications and treatment options considered appropriate (to include usual side effects) verbally and in writing when requested.
5. Take all steps possible to assure confidentiality of treatment and treatment records, within the guidelines established by the State of California.

I agree to abide to the best of my ability by the above.
*********provider signature**********

Patient's Responsibilities

1. I agree to notify the doctor of all significant medical, psychiatric, or substance abuse problems I have had which may relate to my current situation
2. I agree to notify the doctor immediately of any legal issues I am aware of which may involve the doctor in terms of reports, subpoenas for records, or testimony.
3. I agree to notify the doctor if I have urges to hurt myself or anyone else, if I feel I am unable to contain these urges. I agree to go to the nearest Emergency Room if I am unable to reach the doctor fast enough.
4. I agree to ask the doctor if I need anything in writing. This includes medication instructions, potential medication risks, diagnostic reports, or notes for employers.
5. I agree to allow diagnostic psychiatric evaluation by Dr. Gelbart. I understand that after the evaluation he will make recommendations for treatment. By scheduling follow-up visits I am giving my consent to treatments recommended by Dr. Gelbart during our sessions.
6. If I am working with Dr. Gelbart for medications and another therapist for psychotherapy or counseling, I will take responsibility for clarifying the role of each clinician. I understand that Dr. Gelbart cannot be responsible for what the therapist does or does not do. I understand that Dr. Gelbart is not supervising or "backing up" my outside therapist or counselor.

I agree to abide to the best of my ability by the above.

Please Sign

_____ _____

Patient/Representative Signature Date