FAY M. AZAD, MD

Adult & Adolescents Psychiatry

NPI #: 1376647313 Lic #: A41441

12636 High Bluff Drive # 400, San Diego, CA. 92130

(818) 889-8555

I agree to participate in a telemedicine consultation with Fay M. Azad, MD for the psychiatric medication follow up visits via phone or virtual meeting on doxy.me/drfayazad. I understand potential benefits and constraints of telemedicine. I am aware of Dr. Azad's office policy regarding no show or late cancellation.

Patient's name: _____DOB: _____

Mailing address: _____City: _____

Zip code: _____ Cell phone #: _____Email: _____

Emergency contact: _____Phone #: _____

Preferred pharmacy: _____ Pharmacy Address: _____

City & Zip code: _____ Pharmacy Phone #: _____

Credit Card information:

Cardholder name (as shown on card): _____

Card Number: _____Expiration date (mm/yy) _____

Security code: _____ Cardholder zip code: _____

You may also make payment by transferring fund/ your visit's fee to BOA 818 889 8555.

I, _____, authorize Fay M. Azad, MD to charge my credit card as above for agreed services and missed appointments. I understand that my information will be saved to my medical file for future transactions. I may cancel this authorization by contacting Dr. Azad. This authorization will remain in effect until cancelled.

Patient Signature: _____ Date: _____

Card holder signature: _____ Date: _____