BIJAN POURAT, M.D., F.R.C.P., (C), INC.
CARDIOVASCULAR DISEASES ⬩ INTERNAL MEDICINE ⬩ HEALTH OPTIMIZATION
9001 WILSHIRE BLVD. SUITE 308
BEVERLY HILLS, CALIFORNIA 90211
(310) 734-7303

PATIENT AGREEMENT

Welcome to our practice

We are committed to preventive medicine and strive to provide you with the best care possible. We are dedicated to prevention and treating the root causes of illness rather than keeping symptoms at bay. Your evaluation will include a comprehensive look at your entire body. This will include sophisticated laboratory testing as early abnormalities cannot be detected by any other means. Our patients are usually referred by another physician and it is important for you to maintain your own Internist and Cardiologist even though we are board certified to treat these conditions. We are unable to take care of patients in emergencies or acute hospitalizations.

After a complete evaluation, including sophisticated laboratory testing we will make recommendations related to your use of medications and supplements as well as changes in your diet and exercise program. We want you as an active, informed participant in your healthcare and we will do our best to provide you with the materials that would help in your education. We do not guarantee that you would get better but our practice has a high success rate for improving complicated and sick patients.

Our practice charges for physician time required for letter writing, record/lab review, form completion, reviewing lengthy emails, phone calls, and other requests that occur outside of a scheduled appointment. We do not accept any medical insurance nor do we provide billing to insurance companies. You are responsible for payment of laboratory services directly.

We have chosen to limit our practice to fewer patients so that we may allocate more time to your care and individual needs. Optimizing your health is our most important priority.

I understand the above statements and consent to treatment.

_____ _____

 Print Patient Name   Print Parent/Guardian name (if applicable)

 _____ _____

Patient/Guardian signature   Date