Ray Psonak D.O.
255 Intervale Road
New Gloucester, ME 04260
207-657-4325 Fax: 207-517-2619
Alt Fax: 757-315-8052

Agreement for Medical Phone Consultation Please print clearly

Patient's full legal name: _____ today's date: ____/____/ ____

Address: _____ Birth date ____/____/____ Sex: M / F

_____ ZIP _____ Age: ____ marital status _____

Home phone: (_____) _____ Work: (_____) _____ Cell: _____

E-Mail _____ FAX _____

Parents name(s) if child _____

Nature of Phone consultation with Ray Psonak D.O.: I understand that a medical phone consultation (consult) is not intended to replace a relationship I have with my local physician. I may share, if I wish, the information I have gained from the consult. If I do not have a local clinician, I agree to seek one if needed who will provide medical services, such as face-to-face examinations. If I need care on an emergency basis, I agree to seek the services from a local medical emergency facility, such as a hospital emergency room. I further understand that recommendations by Dr. Psonak are based only on information supplied in this medical history form, information disclosed during the phone consult, and medical records which I have the option to supply and pay to be reviewed by Dr. Psonak prior to the phone consult.

Charges for phone consult: The fee for a Phone consult with Dr. Psonak is $120.00 for the first 30 minutes, plus $3.00 per minute for each additional minute. I will fax this form, credit card information and signature to Fax # 207-517-2619. I will call the office at 207-657-4325 to schedule an appointment for the consult at which time my credit card will be charged $120.00. After the phone consult with Dr. Psonak, I agree that my credit card will be charged for any additional fee time beyond 30 minutes, plus any preparation time requested by me. Dr. Psonak is not responsible for ending the telephone consult at the end of the amount of time I decide to consult; if the consultation extends beyond that time, I am responsible for the fee for the entire accumulated time of the consultation.

Charges for reviewing records and follow-up:. (1) In the instance I submit records to Dr. Psonak for review, I understand I will be charged for the time Dr. Psonak spends preparing for my consultation(s). (2) The amount of time he must spend preparing depends on the number and type of documents I provide prior to my consultation. (3) If I am concerned about the cost of the preparation by Dr. Psonak, after submitting the documents for review, but before the consultation, I will inquire of the office at 207-657-4325 what will be the cost of preparation; I will either agree to pay the estimated fee or stipulate a fee; if I stipulate a fee, I understand that this may limit the number of records I have submitted that Dr. Psonak will be able to review before my consultation. (4) I will be charged for any follow up emails/questions that are submitted by me, after the initial consultation, wherein an expectation of a response from Dr. Psonak is requested by me. (5) Dr. Psonak's fee rate for such services is $3.00 per minute. These fees are in addition to the fees for the time Dr. Psonak spends with me on the telephone.

Records for Dr. Psonak to review: I understand that before my telephone consultation(s), I am free to provide Dr. Psonak with documents for review; the records should contain information that I believe may prepare him to provide me with educational information relevant to the concerns I want to consult him about. I am free to provide him with a letter of introduction about myself and my health concerns, along with supporting documents, and with a list of questions or concerns I would like for him to address. I will send to Dr. Psonak the records for review by fax to 207-517-2619 or by email to confidential@ChelationMC.com . Records must be received by Dr. Psonak at least 24 hours prior to my scheduled phone consult.

Cancellation Policy: To reschedule or cancel my appointment for a telephone consultation, I agree to notify the office at least twenty-four (24) hours before the scheduled appointment. I will send the notice of cancellation by email to scheduling@chelationmc.com , by telephone to 207-657-4325, or by fax to 844-263-6886. If I fail to reschedule or cancel twenty-four (24) hours before the appointment time, I understand my initial payment of $120.00 will not be refunded.

Patient or Guardian Signature: _____

Credit card: _VISA _Master Card _Discover Card # _____

Name on Card: _____ Expiration date: ____ / ____ CVV _____

Billing Zip Code: _____

Signature of card holder: _____ Today's Date: ___/___/___