Ray Psonak D.O.
255 Intervale Road
New Gloucester, ME 04260
207-657-4325   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 the Medical History form below, 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 # 757-315-8052. 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 757-315-8052 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 757-315-8052. 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: ___/___/___

Medical History for Phone Consult

Today's Date ___________________

Patient Name_______________________________________ Date of Birth __________________

Your Height: ______________ Your Weight: _______________

Main Problems (Chief Complaint):

List the main problems that you wish to address - current medical problems/date started

____

____

____

____

____

YOUR SYMPTOMS (History of Main Problems):

Please list any symptoms that you have now or experienced: (Please check past or present and how severe and frequent the problem)

		Past	Present	How severe	How Frequent
1.	Headaches	☐	☐	______________	______________
2.	Problems with vision, hearing, taste or smell	☐	☐	______________	______________
3.	Chest Pain or shortness of breath	☐	☐	______________	______________
4.	Cough, wheezing or other difficulties	☐	☐	______________	______________
5.	Heartburn, gas, bloating, indigestion	☐	☐	______________	______________
6.	Constipation, diarrhea, hemorrhoids	☐	☐	______________	______________
7.	Urinary tract problems, stones, infections in the bladder or kidney	☐	☐	______________	______________
8.	Gynecologic problems(specify)	☐	☐	______________	______________
9.	Infertility, impotence, low libido	☐	☐	______________	______________
10.	Skin or hair problems	☐	☐	______________	______________
11.	Bone or joint disorders	☐	☐	______________	______________
12.	Neurological problems, Fasciculations	☐	☐	______________	______________
13.	Mood, emotion, or psychiatric problems	☐	☐	______________	______________
14.	Fatigue, night sweats, loss of motivation	☐	☐	______________	______________

Allergies or adverse drug reactions: (List Known Allergies to medication and type of reactions)

____

____

Other Allergies: Check all that apply:

☐ Dairy ☐ Wheat ☐ Corn ☐ Eggs ☐ Peanuts ☐ shellfish ☐ Chemicals ☐ DON'T KNOW

Do you react to pollen? ☐ Yes ☐ No Reaction ____________________________

Do you react to molds? ☐ Yes ☐ No Reaction ____________________________

Do you react to foods? ☐ Yes ☐ No Reaction ____________________________

Blood Type: Do you know your blood type? (Circle One) O A B AB (Circle One) Positive or Negative

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

NUTRITIONAL & HERBAL SUPPLEMENTS

Preparation	Dose	How often taken

Habits: Do you smoke? No_____ Yes_____

If yes, how many packs per day?___________________________

If you have quit, how long ago? ________________________

Do you use alcohol? No_____ Yes_____

If yes, how often do you drink?____________________________

Do family or friends worry about your alcohol intake? _________

Have you ever had problems with drug use?__________________

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/caffeine					
Aspirin					
Laxatives					
Exercise					
Meditation					

ILLNESSES & DISEASES (Past Medical History):

Date of last complete checkup _____________ Results _________________________________

PAST MEDICAL HISTORY:

Please list all Accidents and Injuries:

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list any surgeries (operations), reason for the surgery, and date of surgery:

FAMILY HISTORY: Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Allergies								
Asthma								
Cancer (specify)								
Heart disease								
Stroke								
Lung disease (specify)								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Neurologic disease (specify)								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

REVIEW OF SYSTEMS:

SYMPTOM REVIEW

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs

pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ bleeding between periods

date of last mammogram________________________

Men only
- ☐ Elevated PSA

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

WORK HISTORY

Current Occupation: ____ How Long? ___________________

Past Occupations: ____ How long? ___________________

____ How long? ___________________

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Thank you for taking the time to complete this form.

PLEASE FAX THIS COMPLETED QUESTIONNAIRE TO 757-315-8052 AT LEAST 24 HOURS PRIOR TO YOUR PHONE CONSULT