LEDA MEDICAL

12 E 44th St. 4FL New York, NY 10017 | Tel: 212-288-8832 / Fax: 212-257-7003

PHONE INTERVIEW FORM

FORM SUBMISSION

- Complete and sign both pages. Billing / credit card information MUST be filled out.
- Fax over the forms to 212-257-7003 or email to contact@ledamedical.com
- Our office will call you to schedule a phone interview

PHONE INTERVIEW FEES / POLICY

- **PLEASE DO NOT SENT IN YOUR MEDICAL RECORDS / LABS, ETC. THEY WILL NOT BE READ**.(Please have them ready as provider might refer to them during your interview)
- $650 = 30 min phone interview
- Any additional time requested / needed after 30min it will be subject to our pro-rated fee schedule below
  - 1-15min = $150 | 15-30min = $300
- There is no Medicare or commercial insurance reimbursement for this service. No Claim form will be provided.

CANCELLATION POLICY -- NO EXCUSES!

There will be a $500 charge to your credit card if;

1. No show to your scheduled phone appointment
2. Same day cancellations

❖ To avoid cancellation fee, you must call us to cancel or reschedule your phone interview 24 hours prior to your appointment.

DISCLAMER

Phone interview does not replace a proper consultation. Our providers do not assume any responsibility as your treating physician. Phone interview is **advice-only**. Medical prescriptions, phone interview note, blood work orders, and care directives/referrals are NOT provided for phone interviews. No further assistance will be made or questions answered by our providers or the staff once the phone interview is over. That may include follow up questions regarding but not limited to: clarification, medication names and dosage, lab orders, plan of action, etc. Phone interview / medical advice rendered by one of our clinicians will is subject to their professional judgment without seeing you in person. Clinician reserves the right to deny advice & care for potential misuse of service, and voice recording is not allowed during the session at any time. Consultations are billed with our provider's clock and is considered to be an accurate counter.

BILLING RESPONSIBILITY -

PERSON RESPONSIBLE FOR BILLING	O SELF	O FATHER	O MOTHER	O SPOUSE	O OTHER
NAME ON CARD:			CARD # **(NO AMEX)**		
EXP:	SEC CODE:	ZIP:	TYPE:		

Payment is due at the time of the visit. Payment is for clinicians' time spend that day discussing, analyzing, strategizing and providing medical opinion. Client may not claim nor pursue charge backs or dispute charges after the service was provided. There will be a 4% convenience fee for all credit card transactions.

My signature below represents that I have read and understood above policies and fees. I understand that providers of LEDA Medical are no my treating physicians. I also understand and acknowledge that this phone interview is Advice Only session. My current treat doctor or caretaker will continue my medications and treatment plan. I have had the opportunity to ask questions prior to session and my questions have been answered to my satisfaction, and I give my consent

☒ **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE X**_____**DATE**_____/_____/_____

PHONE INTERVIEW QUESTIONNAIRE

PLEASE DO NOT SENT IN YOUR MEDICAL RECORDS / LABS, ETC. THEY WILL NOT BE READ.

PATIENT NAME _____ DOB: _____ AGE: _____ SEX: _____

LEGAL GUARDIAN NAME: _____RELATIONSHIP TO PATIENT:_____ _____

ADDRESS: _____APT / SUITE _____ STATE: _____

ZIP _____BEST CONTACT NUMBER _____EMAIL_____

PRIMARY INSURANCE NAME: _____ INSURANCE ID#: _____

PRIMARY INSRUANCE HOLDER NAME: _____ DOB: _____PHONE NUMBER: _____

BRIEF ILLNESS SUMMARY: WHEN DID THE SYMPTOMS BEGIN?

TOP CURRENT SYMPTOMS

PAST AND CURRENT TREATING PHYSICIANS:

CURRENT MEDICATION	STRENGTH / DOSAGE	FREQUENCY (EX. QDAY, BID, TID)	INDICATION	INITIATION	HOW IS PT TAKING THE DRUG?
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	

SUPPLEMENTS

				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	
				1-6 M | > 6M	

ALLERGY TO MEDICATION:

RESENT LABS, IMAGING AND DIAGNOSTIC TEST RESULTS:

MRI:		IGENEX:	
LUMBER PUNCTURE:		GALAXY:	
SPECT SCAN:		WESTERN BLOT / ELISA:	
EMG/NCV:		MOLECULERA (PANS/PANDAS)	
EEG		VIBRANT WELLNESS:	

⌧ SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE X_____DATE_____/_____/_____