ELENA FRID M.D.

151 E 62ND ST. NEW YORK, NY 10065 | Tel: 212-288-8832 / Fax: 212-257-7003

PHONE INTERVIEW FORM

PHONE INTERVIEW - HOW TO SCHEDULE

- Complete and sign both pages. Complete ONLY the pages provided. **PLEASE DO NOT SENT IN YOUR MEDICAL RECORDS / LABS, ETC. THEY WILL NOT BE READ**.
- Complete billing / credit card information
- Fax over the forms to 212-257-7003
- Our office will call you to schedule a phone interview.

PHONE INTERVIEW FEES / POLICY

- $500 / 30 min phone interview with Dr. Elena Frid
  - If additional time requested will be charged at a rate of $500/30min
- Phone interview fee of $500 will be applied towards your initial in-office consultation if you choose to come to us within 6 months of your phone interview, at which point you will be charged a $1000 vs. $1,500 for your initial in-office consultation.

PHONE INTERVIEW CANCELLATION POLICY

There will be a $250 charge to your credit card if a scheduled phone interview appointment is not cancelled or rescheduled within 24hr notice. All late cancellations or no call-ins will be billed. NO EXCUSES !

PATIENT PHONE INTERVIEW DISCLAMER

- Phone interview does not replace proper in-office consultation.
- Dr. Elena Frid does not assume any responsibility as your treating physician. Phone interview is advice-only. Treatment orders, prescriptions, labs, medications, phone interview note, claim forms, and care directives/referrals are not PROVIDED for phone interviews. If after your phone interview, you would like to become one of Dr. Frid's patients, please contact our office to receive a full patient packet.
- No further assistance will be made by Dr. Elena Frid nor Elena Frid MD PC staff once the phone interview is over. That may include, but not limited to: medication, lab, or orders names, plan of action etc.
- Phone interview / medical advice rendered by Dr. Elena Frid and her staff is subject to their professional judgment.
- ELENA FRID MD PC reserves the right to deny advice & care for potential misuse of services.
- Phone interview voice recording is not allowed at any time.
- You may request additional phone interviews, which will be billed at $500 / 30min

BILLING RESPONSIBILITY

PERSON RESPONSIBLE FOR BILLING: ◯ SELF ◯ FATHER ◯ MOTHER ◯ SPOUSE ◯ OTHER

CARD HOLDER NAME: _____ PHONE _____

FULL BILLING ADDRESS _____

CREDIT CARD # _____ NAME ON CARD: _____

BILLING ZIP : _____ EXP DATE _____ SEC. CODE _____ VISA / MC / AMEX _____

My signature below represents that I have read and understood above policies. I understand that Dr. Elena Frid (Elena Frid MD PC) will not and is not my treating physician. I understand that Dr. Elena's Frid's phone interview is Advice-Only. My current treating doctor or caretaker will continue my medication and treatment plan. I also acknowledge that there is no Medicare or insurance reimbursement for this service. I have had the opportunity to ask questions and my questions have been answered to my satisfaction, and I give my consent.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE X_____ DATE _____/_____/_____

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PHONE INTERVIEW QUESTIONNAIRE

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PATIENT NAME _____ DOB: _____/_____/_____ LEGAL GUARDIAN NAME: _____

ADDRESS: _____APT _____ STATE: _____ CITY: _____ZIP _____

BEST CONTACT NUMBER (_____)_____EMAIL_____

WHEN DID THE SYMPTOMS BEGIN? PLEASE PROVIDE THE APPROXIMATE DATE WITH THE ONSET OF SYMPTOMS:

TOP CURRENT SYMPTOMS / BRIEF ILLNESS SUMMARY :

PAST AND CURRENT TREATING PHYSICIANS:

CURRENT MEDICATION REGIMENT:	STRENGTH / DOSAGE (EX. 25MG X2)	FREQUENCY (EX. QDAY, BID, TID)	INDICATION	INITIATION (PLS CIRCLE ONE)	HOW IS PT TAKING THE DRUG?
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
CURRENT SUPPLIMENTS:					
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	
				1-6 MONTHS | > 6 MONTHS	

ALLERGY TO MEDICATION:

DIAGNOSTIC / LAB TEST FINDINGS:

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE X_____ DATE _____/_____/_____