



NEW ENGLAND  
PODIATRY

## TELEPHONE ADVICE CONSENT

Patient Name (please print): \_\_\_\_\_

1. I understand that I wish to engage in a telephone discussion seeking advice regarding my symptoms.
2. I understand how the telephone conferencing will be used to educate only. This is not intended to be the same as a direct patient health care provider visit/treatment since I will not be in the same room and be directly examined by the advisor.
3. I understand there are potential risks to this telephone discussion as I am not being examined.
4. Confidentiality of the information will be maintained.
5. I understand that there are alternatives to a telephone consultation. In choosing to participate in a telephone consultation, I understand that some parts of an examination involving physical tests, X-rays, laboratory tests are impossible.
6. I understand that if my condition is deemed a potential emergency, I will be referred to an emergency/urgent care facility immediately.
7. I will have a direct conversation with a doctor.
8. By signing this form, I certify: That I understand this process. That I fully understand the risks, benefits and convenience of the telephone interview/discussion. That I will be given ample opportunity to ask questions. That this call is not covered by or reimbursed by health insurance companies.
9. I understand that I will be charged \$150.00 for this discussion. **No fee will be charged** if it is quickly determined that a visit or a referral is necessary. Fee is paid **prior** to telephone discussion and is **nonrefundable**.

### Disclaimer and Release:

I hereby completely and irrevocably release New England Podiatry Associates (NEPA) and its parent and sister corporations and their respective medical staff members, physicians and other health care professionals, administrators, officers, employees and directors of any and all errors and omissions, known or unknown, foreseen or unforeseen, knowingly or unknowingly, as well as all claims, actions or damages arising from or in connection with the telephone opinion consult, conclusions or recommendations provided by NEPA or its physicians. Furthermore, I agree that the NEPA Released Parties have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its transmission. As a condition to receiving the telephone consult service, I have read and acknowledge that I have given this consent of my own free will. By accepting and agreeing to these terms, I acknowledge and agree to assume the risks of the limitations set forth herein.

\_\_\_\_\_  
Patient's /parent / guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

**Fax completed form to: 617 566 3919**