TENNESSEE REPRODUCTIVE MEDICINE

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Phone Consultation Disclaimer Form

_____ _____/_____/_____
Patient Name (Please print) Patient DOB

By signing this form I acknowledge and understand the following:

1. My medical condition will be discussed with me based on the information that has been provided to Tennessee Reproductive Medicine (TRM) by (1) copies of medical records in which I have authorized to be released and/or (2) information that I have provided either orally or in writing.
2. I acknowledge that the reasons for and/or the purpose of the recommended test/treatment/procedure will be explained to me based on the information provided to TRM as referenced in #1 above.
3. I understand that important medical information is often gathered by an in-person consultation including the face to face discussion, vital sign measurement and physical examination, and I acknowledge that without me physically appearing for my consultation, it is possible that incomplete information is available to the provider at TRM and that incomplete recommendations may be made based on this lack of information. However, I acknowledge that the convenience of initiating a clinical relationship via phone consultation may outweigh these risks initially. I understand that I may be advised to have additional testing and treatment after an in-person consultation and examination, which in some cases can delay the start of treatment. The TRM physicians will make every attempt to expedite testing but reserve the right to adjust medical conclusions and recommendations until an in-person visit is conducted.
4. I acknowledge that for a "New Patient" Phone Consult, insurance will not be filed with insurance as this is considered a non-covered service and a $300 fee must be paid to schedule an appointment. If I am not available at the time the physician contacts me for the appointment consultation, the $300 will be forfeited as the reservation has been blocked specifically for my appointment. I understand that emergencies can arise in which the physician may not be able to contact the patient at the exact time of the appointment and I will continue to be available 15 minutes after my appointment time in order for the provider to contact me. TRM will make every effort to update the patient in the case of unexpected delays in the schedule.

By signing this form I acknowledge and understand that the practice of medicine is not an exact science, and that no guarantees will be made to me as to the results of the test/treatment/procedure.

By signing this form I acknowledge and understand that unforeseen conditions might arise during the tests/treatments/procedures, necessitating the performance of additional tests/treatments/procedures.

I have read the above consent form. I fully understand it and authorize my physician to contact me about their review of my condition and his/her recommended test/treatment/procedure.

_____ _____/_____/_____
Patient Signature Date

****Copy of Photo ID must be returned with this form.****