Informed Consent and Registration for Online Video / Phone / Email Consultations

If you need to consult or follow-up by mail, phone, online videoconference or email with our doctors, you need to register for the service. This is to inform you the nature of the services, and that you should agree to the following:

We are limited in our professional liability towards you in a phone or email encounter [hereinafter "encounter(s)"] since impersonal follow-up does not represent a complete diagnostic or therapeutic episode and may not be recognized legally or by insurances. Such encounters are no substitute for in-office follow-up appointments. As such, these encounters are only offered as a service for your convenience and at our doctors' discretion. You will thus agree NOT TO HOLD MERIDIAN MEDICAL or ITS DOCTOR(S) liable for diagnostic or therapeutic recommendations, suggestions or opinions provided based upon such encounters, and sign to the effect below in order to register for the service.

- Time: It takes time for us to review ongoing records and provide written or verbal response to your situation, and although most emails and phones are answered within 24 hours, you should understand that there could be a delay for a response or to set up a phone appointment. Please let us know in case there is any urgency involved.

- Mutual Obligation: Our willingness to monitor your situation and tests or manage your case does not necessarily imply our ability to diagnose or treat you in a timely matter at all times especially via email or phone encounters. We reserve the right to decline to follow your case if we feel that the follow-up is inadequate to protect your health and conversely you may decide to no longer follow-up with us. As such, this registration can be terminated by us/ you at any time with a one week notice in writing.

- Fees: Fees are charged based upon time and effort for all consulting and all reasonable related professional or office activities (including but not limited to communication with other physicians, specialists or designates upon your request or on your behalf, ordering of labs, reading and review of reports or scans or test results, provision of prescriptions or orders or letters or completion of official insurance or benefits or claim forms on your behalf) and are defined below. The general rate for the various kinds of work we provide is $900 per hour dependent on the complexity of the effort involved. This fee is generally not deemed reimbursable by insurance and no formal insurance claim forms will be signed, submitted or provided. In case of a very complex or unusual situation (difficult or rare cases, overseas patient etc.), we reserve the right to require a retainer to accept the case for long-distane and/or virtual consultations and management.

- Billing: Work will be billed based on time at the rate indicated below and charged to the credit card on record as provided. For Dr. Chang, you will be billed at the rate of $900/hour for all work (billable at 0.2 hr minimum and 0.1 hr units per hr increments). You will be billed after the service and will receive an itemized bill. If you have been charged a retainer, the fees will be deducted from your retainer, and you will receive a periodic bill. Please contact us immediately if you do not understand or disagree with any charges, and we will promptly review and xxplain the service to you. We reserve the right to terminate services immediately if fees are unpaid.

  For your email consultations: you will use consult.chang@meridianmedical.org to email your doctor. The billable amount will be indicated in the subject line on any reply email to you, (e.g. 0.2, 0.3 etc) At the discretion of the doctor, if there is no charge, there will be "n/c" on the subject line. For phone consultations, please call us to make an appointment.

Your signing below indicates that you have read, understood and agree with the above and voluntarily register for service and you allow us to place and charge your credit card on file for according to terms above.

Above read and agreed†, Date

_____ _____

(Patient or Guardian if under 18 years)

CC: VISA/ME Expiry Date

_____ _____

†Signature above also indicates agreement for my card to be charged as per rate and terms above for services rendered as described above.