Dr. Anna Cabeca

Virtual Consultation Disclosure & Consent

Name: _____ Date: _____

Address: _____

Phone #: _____ [OR]
Skype UserName: _____ [OR]
FaceTime Phone #: _____

Skype or Zoom consultations are offered as a convenience for out of town patients. All paperwork must be completed, signed and returned to our office a minimum of 24 hours prior to the appointment, along with a valid photo ID. Email to: lori@cabecahealth.com
The physician's fee for your phone/Skype Consult is $600.00.

I, _____, consent to a Skype or phone consultation with Dr. Anna Cabeca. I acknowledge that it is only a consultation and not a substitute for medical care. I have been advised to seek medical care locally and have a relationship with a local physician for my medical needs. I also acknowledge receipt of the above disclosure statement and give my informed consent for Consultation by Dr. Anna Cabeca.

Name and address of local physician:

_____
_____
_____

Credit Card Authorization Form I, (please print name) _____, authorize Dr. Anna Cabeca staff to charge my credit card for the following reasons: mail orders/products, phone consultation and cancellation fees.
Credit Card (Please circle one) Credit Card #: _____
Billing Address for Listed Credit Card: _____ Expiration Date: _____
3-Digit Security Code: _____
Patient or Card Owner Signature: _____
Date: _____