CONSULTATION REQUEST AND AGREEMENT

SynerGenius TELEPRESENCE

| 600 17th Street, Suite 2800 South| Denver, Colorado 80202-5428 | Phone: 720-515-1315 | Fax: 720-528-7755 |
| www.synergeniustelepresence.com | E-mail: info@synergeniustelepresence.com |

NAME OF PATIENT: _____ DATE OF BIRTH: ____ / ____ / ____

I request SynerGenius Telepresence to provide an integrative psychiatric consultation for the above-named patient. My patient and I have discussed this request and we understand the risks and limitations of this service. I also understand I will receive a copy of the assessment and recommendation and will review it with the above-named patient. I will adopt those of its recommendations, and write for those of its recommended prescription medications, as in the exercise of professional judgment I deem appropriate. I acknowledge and agree that SynerGenius Telepresence will not perform those functions; rather, it is my prerogative and responsibility to do so. I acknowledge and agree that I will provide any necessary after-hours or vacation-time care, follow-up care, or crisis management for my patient.

PROVIDER SIGNATURE _____ DATE: ____ / ____ / ____

(Please Print)
Treating/Referring Physician/Provider Name: _____

Name of Practice: _____

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ - _____ Office Fax: (_____) _____ - _____

Email: _____

☐ This email address is HIPAA-compliant and appropriate for receipt of PHI and/or discussion of treatment recommendations.