

**Agreement to the Terms of  
Telephone Educational/Informational Consultation(s) with  
Dr. John C. Lowe, LLC**

My name is (please print)\_\_\_\_\_. This form with my signature below is my agreement to the terms of telephone educational/informational consulting with Dr. John C. Lowe, LLC. (Below, “consultant” refers to Dr. Lowe, and “consultee” refers to you, and anyone else consulting with him on your behalf, as the person who is the beneficiary of Dr. Lowe’s educational/informational consulting service.) **I understand the following:**

**1. Nature of My Consultation(s) with Dr. Lowe:** (1) I have read Dr. Lowe’s biography at [www.drLOWE.com/jcl/biojcl.htm](http://www.drLOWE.com/jcl/biojcl.htm). (2) Dr. Lowe is a researcher and educator, not a licensed clinician, and consulting with Dr. Lowe does not imply that I have a clinician/patient relationship with him. Instead, my relationship with him through long-distance consulting is a *health education/information counseling relationship*. (3) I agree to work with my current clinician(s), sharing, if I wish, the information I have garnered from my consultation(s) with Dr. Lowe. If I do not have a local clinician, I agree to seek one who will provide clinical services, such as face-to-face examinations, if I should need them. (4) If I need clinical services, especially on an emergency basis, I agree to seek the services from a local clinician or a medical emergency facility such as a hospital emergency room.

**2. Charges for Consultations:** (1) I will fax this form containing my agreement information, credit card number, expiration date, and signature to Dr. Lowe’s electronic fax number, which is 303-496-6200. If I prefer not to fax my credit card information, I will provide it by telephone when I schedule an appointment to speak with Dr. Lowe. After a telephone consultation with Dr. Lowe, I agree that my credit card will be charged for the telephone consulting fee and any other fees I agree to through this form or during the consultation. The fee for consulting will be the appropriate dollar amount for the cumulative time of the consultation. The rate is \$5.00 per minute. (2) Dr. Lowe is not responsible for ending the telephone consultation(s) at the end of the amount of time I prefer to consult; if the consultation extends beyond that time, I am responsible for the fee for the entire accumulated time of the consultation. (3) I agree that I am held responsible for providing a valid method of payment and in the event that my credit card charge is denied, I will be subject to an insufficient fee that will be applied to the consultation charges.

I understand that if I request it, Tammy Lowe will provide me with a receipt for the charges for the consulting service(s) I have paid for. However, I understand further that Dr. Lowe is no longer a licensed clinician, and because of that, I will not receive a superbill with diagnostic and/or treatment codes for the purpose of insurance reimbursement.

**3. Charge for Preparation.** (1) I will be charged for the time Dr. Lowe spends preparing for my consultation(s) by reviewing and considering the contents of the records I submit to him for review. (2) The amount of time he must spend preparing depends on the number and type of documents I provide prior to my consultation. (3) If I am concerned about the cost of the preparation by Dr. Lowe, after submitting the documents for review, but before the consultation, I will inquire of Tammy Lowe what will be the cost of preparation; I will either agree to pay the estimated fee or stipulate a fee; if I stipulate a fee, I understand that this may limit the number of records I have submitted that Dr. Lowe will be able to review before my consultation. (4): I will be charged for any follow up emails/questions that are submitted by me, after the initial consultation, wherein an expectation of a response from Dr. Lowe is requested. (5) Dr. Lowe’s fee rate for such services is \$5.00 per minute. These charges are in addition to the charges for the time Dr. Lowe spends with me on the telephone.

**Records for Dr. Lowe to Review:** I understand that before my telephone consultation(s), I am free to provide Dr. Lowe with documents for review; the records should contain information that I believe may prepare him to provide me with educational information relevant to the concerns I want to consult him about. I am free to provide him with a letter of introduction about myself and my health concerns, along with supporting documents, and with a list of questions or concerns I would like for him to address. I will send to Dr. Lowe the records for review by fax to 303-496-6200 or by email to [Tammy@drLOWE.com](mailto:Tammy@drLOWE.com) and [Consultations@drLOWE.com](mailto:Consultations@drLOWE.com). It is not necessary, however, that I provide Dr. Lowe with such test results or health records if I choose not to do so.

**Cancelling an Appointment:** To reschedule or cancel my appointment for a telephone educational/informational consultation, I agree to notify Tammy Lowe or another representative of Dr. Lowe at least twenty-four (24) hours before the scheduled appointment. If my appointment is on Monday, I will phone, email, or fax to reschedule or cancel on the Friday before. I will send the notice of cancellation by email to [Tammy@drLOWE.com](mailto:Tammy@drLOWE.com), by telephone to 603-391-6061, or by fax to 303-496-6200. If I fail to reschedule or cancel twenty-four (24) hours before the appointment time, I agree that my credit card will be charged a fee of \$150.00 for thirty (30) minutes of the time that had been reserved for me.

**Dispute Resolution:** I understand that the terms of this agreement may be enforced against any person or entity associated with Dr. Lowe’s practice only in Palm Beach County in the state of Florida, the United States of America, and under the internal laws of the state of Florida the jurisdiction of which I agree to submit. The contents of this form constitute the complete agreement between Dr. John C. Lowe, LLC and me for educational/informational telephone

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consultations and preparation, and when I sign the agreement, the terms of the agreement will apply to any telephone consultation and any related communications through other media I have with him.

**Faxing this Form & Scheduling an Appointment:** After filling in the lines below, I will sign this form and fax it to 303-496-6200 or email it to [Tammy@drlowe.com](mailto:Tammy@drlowe.com) in a format that includes my signature. If I have not already scheduled my telephone consultation, I will phone Dr. Lowe's main telephone number, 603-391-6061, to set the day and time of my appointment. At the time of my scheduled consultation, either Dr. Lowe will phone me, or I will phone Dr. Lowe's consultation phone number 561-622-1125 or another number if Tammy provides one.

**CONTACT AND CREDIT CARD INFORMATION**

**PLEASE NOTE:** WE MUST HAVE THE HANDWRITTEN SIGNATURE OF THE CARD HOLDER BELOW. THE EASIEST WAY TO PROVIDE THIS IS TO PRINT THE WORD, PDF, OR HTML FILE, SIGN IT, AND THEN FAX IT TO US AT 303-496-6200. IF THIS IS NOT POSSIBLE, PLEASE VISIT A KINKO'S OR SOME OTHER SUCH PRINT/COMPUTER SERVICE. OR ASK A FRIEND WHO HAS A SCANNER ATTACHED TO HIS OR HER COMPUTER. HAVE THE PERSON SCAN YOUR HANDWRITTEN SIGNATURE INTO THE COMPUTER AND SAVE IT AS A JPG FILE. THEN, WHEN YOU FILL OUT A FORM SUCH AS THIS ONE, YOU CAN CLICK ON "INSERT," "PICTURE," AND "FILE." IN YOUR FILE STRUCTURE, FIND YOUR SIGNATURE AS THE JPG FILE. IT WILL BE SOMETHING SUCH AS "JOHNLOWE.JPG." CLICK ON THE JPG SIGNATURE FILE, AND YOUR HANDWRITTEN SIGNATURE WILL APPEAR IN THE WORD OR HTML FILE.

WE APOLOGIZE FOR ANY INCONVENIENCE TO YOU, BUT IT IS A *LEGAL NECESSITY* THAT WE HAVE THE CARD HOLDER'S ACTUAL SIGNATURE ON THE FORM. OUR SINCEREST THANKS FOR YOUR COOPERATION WITH THIS.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Fax: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail \_\_\_\_\_

Credit Card Type:  Visa  Master Card Card Number: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name of card holder if not your own (Please print): \_\_\_\_\_

Signature of card holder (if not your own): \_\_\_\_\_ Date: \_\_\_\_\_