VirtualConsultMD

Date: _____/_____/_____

Court Appearance, Testimony, and Deposition Agreement

Client Full Name: _____

I, the above-mentioned, understand that by requesting my therapist/counselor from the office of Virtual Consult MD to appear in court to provide a testimony and/or a deposition will be charged a fee. I understand that these fees are not covered by my insurance and that I am responsible for all fee's incurred.

The following fees are in effect:

- **Preparation Time: $100/hour**
  - Including submission of all necessary documents, forms, or records; phone calls; and electronic forms of communication (i.e. Email).
- **Deposition time: $200/hour**
- **Testimony time: $200/hour**
- **Total time spent away from the office due to deposition or testimony: $150/hour**
  - If court case is located outside of 50-mile radius of therapists/counselors office, the abovementioned fees are doubled. Client agrees to pay for lodging / hotel fee if counselor is staying overnight due to case time restraints.
- **Mileage driven: $0.54/mile (IRS Business Mileage Rate)**
- **Filing a document/form with the court: $50 per document/form**
- **All attorney costs/fees incurred by the therapist/counselor as a result of the legal action**
- **The minimum charge for a court appearance: $750**

A retainer of $750 is due in advance and payable to Virtual Consult MD, which is non-refundable. If a subpoena or notice to meet attorney(s) is received without a minimum of 72-hour notice there will be an additional $250 "express" charge. Also, if the court case is reset with less than 72-hours notice, then the client will be charged $250 (in addition to the retainer of $750).

I understand that even though I am responsible for the testimony fee, it does not mean that my therapist's/ counselor's testimony will be solely in my favor. They can only testify to the facts of the case and to their professional opinion(s).

The signature below acknowledges that the client or the client's responsible party has agreed to the terms set within this agreement with Virtual Consult MD.

_____ _____

(Client / Responsible Party Signature) (Date mm/dd/yyyy)

_____ _____

(Virtual Consult MD Member Signature) (Date mm/dd/yyyy)

VirtualConsultMD

Date: _____/_____/_____

COURT APPEARANCE REQUEST FORM

I. CLIENT INFORMATION:

First Name: _____ Last Name: _____

DOB: _____/_____/_____ [mm/dd/yyyy] Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Mobile Number: _____

II. THERAPIST / COUNSELOR INFORMATION:

First Name: _____ Last Name: _____

III. DATE & TIME:

Date: _____/_____/_____ [mm/dd/yyyy] Time: _____ : _____ ☐ AM ☐ PM

III. LOCATION INFORMATION:

Office or Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

IV. REQUEST REASON:

Briefly Explain: _____

_____

_____

We accept Cash or Check ONLY. Please make Check payable to Virtual Consult MD, LLC

FOR OFFICE USE

**** Please notify all parties of decision for client's request.***
*****Verify that client has been informed of their rights in accordance to HIPAA.***
***** In addition to agreement, ROI must be completed by client or client's legal guardian**

Request Approved: ☐ **Yes** ☐ **No** ***VCMD Member Signature*: _____**

Retainer Amt Paid: ☐ **Yes** ☐ **No** ***Date*: ____ /____ /_____ (mm/dd/yyyy)**