

**Richard M. Siebold, M.D., Inc.**  
**A Medical Corporation**  
**IRS# 95-3434004**

**DEPOSITION REQUEST FORM**

Applicant

Defense

Co-Defense

Name of Firm: \_\_\_\_\_

Firm Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Deposition Re: \_\_\_\_\_ vs. \_\_\_\_\_

Date of Depo: \_\_\_\_\_ Time: \_\_\_\_\_

**LOCATION:** 16311 Ventura Blvd., Suite 1000 Encino, CA 91436

**DEPOSITION FEES:**

\_\_\_\_\_ **IME:** \$500.00 per hour plus \$500.00 for 1 hr preparation fee = **\$1000.00**

\_\_\_\_\_ **AME/ QME** \$312.52 per hour plus \$468.78 for 1 ½ hr preparation fee = **781.30**

Pursuant to title 8, California Code of regulations, Sections 9793, 9794 and 9795, reimbursement for the medical testimony is to be calculated pursuant to the reasonable level fees as promulgated by the legislature.

**CANCELLATION/ REFUNDS:** RMS MD., INC requires ten (10) working days notice for any cancellations or rescheduling. If less than ten (10) days, fee is **\$390.65**. If cancellation is five (5) or less working days, the fee will be **\$781.30**.

**HOLD APPOINTMENTS:** We will not guarantee availability on any hold dates for more than 24 hrs.

**-- I acknowledge and agree to pay.**

--I do not agree to pay.\*

\* (If you do not agree to pay, deposition will not be scheduled)

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

By signing this form, you acknowledge the fees and cancellation policy set forth by RMS MD, INC.

Name of whom should be contacted regarding deposition: \_\_\_\_\_

**PLEASE TAKE NOTE THAT DEPO'S ARE SCHEDULED AS FOLLOWS:**

- Wednesday: 10:00 am, 11:00 am, 12:00 noon & 1:00pm
- Fridays: 11:00 am, 12:00 noon, 1:30 pm & 2:30 pm

CONFIRMATION # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_