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RELEASE OF INFORMATION AND FINANCIAL POLICY

Financial Policy:

Thank you for choosing The Modern Country Doctor, LLC as your health care provider.

If you have health insurance coverage:	If you do not have or choose not to use health insurance:
<ul style="list-style-type: none"> You are responsible for supplying current, correct insurance information for covered services. 	<ul style="list-style-type: none"> Payment in full is due at the time of service.
<ul style="list-style-type: none"> Please notify us of any changes in your physical address, email address or telephone number. 	<ul style="list-style-type: none"> We accept cash, Visa, MasterCard, Discover, American Express, Direct Debit, eCheck, Apple Pay, PayPal and VisaCheckout
<ul style="list-style-type: none"> You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company. 	
<ul style="list-style-type: none"> All co-pays and your estimated portion, including any deductibles and/or co-insurances, will be expected at the time of service. 	

Our business office is available from 8a - 4p, Monday through Thursday and 8a-2p on Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason please contact our business office immediately at (610) 890-8522. A \$35.00 fee will be charged for all returned checks.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by The Modern Country Doctor, LLC. I understand and agree that if the office places my account with an agency or attorney for collection, the offices shall be paid by me for all collection costs to the extent allowed by applicable law. I authorize the release of medical information to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I have read and agree to this financial policy:

Patient Signature: _____ **Date:** _____

Card on File

By signing below, I authorize The Modern Country Doctor, LLC to keep my credit card information securely on-file in my account. I authorize The Modern Country Doctor, LLC to charge my credit card for any outstanding balances when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give The Modern Country Doctor, LLC a new, valid credit card which I will allow them to charge over the telephone. Even though The Modern Country Doctor, LLC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Patient Signature: _____ **Date:** _____



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Release of Information:

May we leave a message on your answering machine or voicemail regarding test results? Yes No

May we leave information regarding your medical care with someone other than you? Yes No

Please indicate with whom we can leave a message regarding appointments and test results:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Signature: _____ **Date:** _____

Receipt of HIPAA Policy:

I acknowledge I have received or declined a copy of The Modern Country Doctor, LLC's Notice of Privacy Policy. This is available from our receptionist or on our website separately at:

<https://moderncountrydoctor.com/legal/071920HIPAAnotice.pdf>

Patient Signature: _____ **Date:** _____

Telemedicine Consent:

I acknowledge I have received and completed a copy of The Modern Country Doctor, LLC's Telemedicine consent. This is available from our receptionist or on our website separately at: _

<https://moderncountrydoctor.com/legal/071920telemedconsent.pdf>

Patient Signature: _____ **Date:** _____