My Country Doctor

Patient Billing Agreement:

I acknowledge the following by my signature below:

PATIENT/LEGAL GUARDIAN SIGNATURE _____

DATE: ____/_____/_____

1. I agree to pay my bill in full at the time services are provided, for any type of encounter, whether it is a traditional Office Visit, a Phone Visit, or an online Virtual Visit. For services performed at my request outside of an encounter (e.g., prescription refill, form completion or referral), I agree to pay for these services in advance.

2. I understand that My Country Doctor and Dr. Paul Ferenchak are not contracted providers with any insurance companies, and are considered 'out of network' and their services may not be covered by my insurance. I understand that Dr. Paul Ferenchak will attempt to work in the constraints of my insurance benefits if possible and at my request.

3. I agree to provide a valid driver's license or other form of identification to be kept securely on file at My Country Doctor.

4. I agree to provide a valid credit or debit card to be kept securely on file at My Country Doctor and hereby authorize employees of My Country Doctor to charge this card for services provided to me and my dependents. I will be notified of these charges in advance of them occurring.

5. I verify that I have reviewed my insurance information listed with My Country Doctor and that it is correct. I understand that I am responsible for knowing what facilities or specialist physicians are preferred with my insurance, and what services may or may not be covered by my insurance. I will provide this information to Dr. Paul Ferenchak when I request he assist me in obtaining recommended services 'in network' in the hopes my insurance will cover them.

6. I understand that My Country Doctor may provide a claim for me to file with my primary insurance carrier as a courtesy, but that it is my responsibility to follow up with my insurance company to insure reimbursement. I understand that My Country Doctor cannot act as an intermediary between me and my insurance company to effect payment.

7. I hereby request and authorize My Country Doctor physician and personnel to deliver medical care to myself or my dependents.

8. I understand that medical records are the property of the physician of My Country Doctor; however, I am entitled to a copy, with sufficient advanced notice, upon my written request (patients aged 18 and older must sign their own medical record release form). I understand that there may be a charge of $20.00 for copies of my medical records.

9. I acknowledge that I can obtain a copy of My Country Doctor's Privacy Practices/Patient's Privacy Rights upon request.

10. I understand that a $60.00 fee will be charged for all appointments missed or not cancelled at least 24 hours in advance.