Thank you for choosing Expedient Med for your medical care. We are committed to providing access to the highest quality of affordable health care at your convenience. We ask that you carefully read the following and sign below to acknowledge your understanding and acceptance.

## CONSENT FOR TREATMENT

I wish to receive medical care and treatment at Expedient Med. I consent to the diagnosis and treatment rendered through telemedicine. I understand that when indicated, the patient may be advised to seek care in person at the nearest emergency department.

I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

## INFORMATION SHARED WITHIN EXPEDIENT MED

I understand that within the Expedient Med practice, my information may be shared electronically or on paper with providers and staff in the course of my treatment.

## DISCLOSURE OF INFORMATION FOR PAYMENT PURPOSES

I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive during this visit, including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol, or other substance abuse. I understand that according to the law, I may choose to pay out of pocket for certain services. If I do not want my health information regarding those services to be provided to my insurance company, I agree to notify Expedient Med of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for the services, the information will be sent to my insurance company.

## FINANCIAL AGREEMENT

I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of Expedient Med. Expedient Med reserves the right to charge a Late Payment Fee, Returned Check Fee, and/or Credit Card Chargeback Fee. If I choose to pay all charges myself, I will notify this office prior to receiving services. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses, and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency. I understand Expedient Med requires a Credit Card on File to expedite claim resolution. I understand I will receive one (1) statement from Expedient Med for any balance assigned to patient responsibility and that my credit card saved on file will be debited for the balance.

## ASSIGNMENT OF BENEFITS

I hereby authorize assignment of the medical insurance benefits I am due to Expedient Med for application to bills for medical services. I further authorize Expedient Med to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due to Expedient Med and not received from my insurance carrier(s). I understand Expedient Med is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

I have read this consent, and I am the patient, or the patient's duly authorized representative/Parent or Legal Guardian. On my own behalf, or on behalf of the patient, I accept and agree to be bound by all of these terms and conditions of services until I revoke this authorization to Expedient Med in writing.