Please use blue or black ink only

PATIENT INFORMATION

First Name	Last Name	MI	Preferred Name

Date of Birth	Social Security Number	Sex ☐ M ☐ F	Marital Status

Address	Apt/Lot #	City/State/Zip

Home Phone	Cell Phone	Email

Emergency Contact Name	Phone	Relationship to PATIENT

Primary Care Doctor or Clinic	Preferred Pharmacy & Location

Race (optional)
☐ White ☐ African American ☐ Pacific Islander
☐ Asian ☐ Native American ☐ Prefer not to answer

Ethnicity (optional)
☐ Non-Hispanic/Latino
☐ Hispanic/Latino

INSURANCE INFORMATION ☐ SAME AS PATIENT

Full Name of INSURED	Address of Insured (if different than PATIENT)		Date of Birth

Insurance Company Name	Policy Number	Group Number	Relationship to Patient

DO WE HAVE PERMISSION TO:

Leave personal information on your voice mail, including but not limited to lab or other test results?	☐ Yes ☐ No
Discuss your medical information with family members?	☐ Yes ☐ No

(If Yes) Name	Phone	Relationship to PATIENT

Email you with updates & events from InstaClinic?	☐ Yes ☐ No

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly the the physician. I understand that I am financially responsible for any balance. I authorize InstaClinic, LLC or my insurance company to release any information required to process my claims. I also authorize the above communication permissions as checked, which will expire one year from date signed.

PATIENT Name (Print)	PATIENT Signature	Date

PATIENT FINANCIAL POLICY

Welcome to InstaClinic, LLC. We are committed to providing the best possible healthcare to you and your family. Understanding your financial responsibility is an essential element of your medical care and treatment.

INSURED PATIENTS: Our office policy is to collect the patient's responsibility for medical care provided at the time of service. We are here to help answer questions you may have regarding your insurance and payments. It is important to understand that your health insurance policy is a contract between you, your employer, and your insurance carrier. It is your responsibility to know what your policy benefits cover. We will collect your co-pay/deductible and file your claims directly to your insurance company. Deductible amounts are based on an estimate of your contracted rate. After your claim has been processed, you will receive a statement for any difference your insurance company applies to your responsibility. In the event your health plan determines a service is "not covered," you will be responsible for the balance upon receipt of a statement from our office.

UNINSURED/SELF-PAY PATIENTS: We understand that not all of our patients have health insurance coverage. Our office policy for self-pay patients is very simple: we have transparent pricing on our website with visits at $99 a month, or memberships at $39 or $79 a month depending on the services selected by the patient. Weight loss medication and other medications delivered to patient's homes are listed on the website. At the time of service we will collect payment in full for all services provided.

CREDIT CARD ON FILE: Payment IN FULL is expected at the time of service. After the first payment is made, the payment method on file will be charged for future orders and services.

MEDICAID/CHIP: We do bill Medicaid for all Wyoming Medicaid patients. Co-Pay will be at the time of service.

MINOR PATIENTS: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent/guardian with custody for payments

CONSENT TO CONTACT You expressly consent and agree that, in order to discuss or service your accounts(s) (the “Accounts “) or to collect amounts you may owe, InstaClinic, LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, “We”) may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Please be aware that if it is medically necessary for the physician to order blood work, you will receive a separate bill from the lab that the blood work is processed through.

We encourage you to call our billing office should you require assistance with your statement. A $25.00 fee is added to your account if it is sent to collections and for non sufficient funds returned check fees.

I have read and understand InstaClinic, LLC's FINANCIAL POLICY. I agree to be bound by its terms.

PATIENT Name (Print)	PATIENT Signature	Date

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS & AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I authorize InstaClinic to release any third party payer or consulting physician any medical records concerning diagnosis and treatment when requested for its uses in connection with determining payment of services rendered and/or further treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I authorize payment directly to InstaClinic for its services as described but not to exceed the reasonable and customary charge for service. I understand that my insurance may or may not be in-network with InstaClinic and/or the physicians providing services. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third part within a reasonable period of time (not to exceed 60 days)

MEDICARE PATIENTS ONLY: I authorize payment directly to InstaClinic and authorize release of medical information to the centers for Medicare and Medicaid Services (CMS) and its agents. In Medicare-assigned cases, the physician agrees to accept the allowed charge determination of the Medicare carrier and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance & deductible are the determination of the Medicare carrier

I PERMIT A PHOTOCOPY OF THE AUTHORIZATION & ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT SACC: This assignment will remain in effect until revoked by me in writing. I understand that it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid by my insurance or third party payer. Should my check for payment be returned for any reasons, InstaClinic will assess a $25.00 return check fee to your account. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections. A $25.00 fee will be added to your account if it is sent to collections.

PATIENT Name (Print)	PATIENT Signature	Date

PATIENT ACKNOWLEDGEMENT & CONSENT

The federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with HIPAA's requirements, we will provide you with a copy of our Notice of Privacy Practices upon request at any time. The Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out the treatment, payment activities, and healthcare operations as explained in our Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: By signing this form, you acknowledge that you have been had an opportunity to read our Notice of Privacy Practices (available on our website and by requesst). Our notice provides a description of our treatment, payment and policies, healthcare operations, and your rights as a patient. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revision, at any time by contacting us instaclinic.com.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation. You understand that the revocation of this consent will not affect any action we took in reliance on the consent before we receive the revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had a full opportunity to read and consider the contents of InstaClinic PATIENT ACKNOWLEDGEMENT & CONSENT and the NOTICE OF PRIVACY PRACTICES of InstaClinic, LLC. I understand that by signing this consent form, I am giving my consent for InstaClinic, LLC to use and disclose my Protected Health Information to carry out treatment, payment activities, and healthcare operations.

PATIENT Name (Print)	PATIENT Signature	Date