QueerDoc, PLLC
CONSENTS TO CARE, PRIVACY, AND FINANCIAL AGREEMENT

Acknowledgement of Receipt of Notice of Privacy Policies

I hereby acknowledge that I have received and reviewed a copy of the QueerDoc PLLC ("QueerDoc") Notice of Privacy Practices. I understand that the terms of this Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my health information has been disclosed.

_____ (initial here)

Consent for Care

I hereby consent to medical care or services performed by QueerDoc and its authorized providers for myself or for the identified patient for whom I am the legal guardian. This medical care may include services and supplies related to my health (or that of the identified person) and may include (but are not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment or review of physical or mental status/function of the body, and the prescription of medication or medical devices and equipment. This consent includes contact and discussion with other health care professionals for care and treatment as necessary. I understand that I have the right to accept or refuse medical care or services at any time.

_____ (initial here)

Financial Agreement

Acknowledgement of Financial Responsibility:

I acknowledge my financial responsibility to pay for all medical care or services received from QueerDoc, including but not limited to all lab fees, regardless of insurance coverage, eligibility or referral status. I understand that QueerDoc does not contract with insurance. I understand that it is my responsibility to contact any laboratory company, as necessary, to provide my insurance information, if any, for billing purposes. In the event QueerDoc is billed for and required to pay for any of my lab fees, I understand that QueerDoc will send an invoice to me for such amount(s) or bill my account on file, that I will be financially responsible to pay such amount(s) and that I am solely responsible for seeking reimbursement from my insurance company for such amount(s), if applicable.

_____ (initial here)

Payment at Time of Service:
Payments are accepted by credit card and administered through a third party payment processing system via QueerDoc's secure online billing through QueerDoc's secure patient portal. A credit card must be on file at time of services. Your credit card will be charged overnight after the day of your visit. If you have a history of late payments or overdue balances, payment will be required at the beginning of any future visits.

_____ (initial here)

Appointment Cancellations:
I understand that visits must be rescheduled or canceled at least 2 business days in advance and that failure to do so will incur a fee of up to the minimum sliding scale payment, billed to the credit card on file.

_____ (initial here)

Collection of Past Due Accounts:
I understand that all unpaid accounts will be sent to collection, and no further services will be provided until the balance on the account is paid in full.

_____ (initial here)

Release of Information:
I authorize QueerDoc to release any medical or financial information necessary to audit any payments for the medical services provided to me (or the identified person) by QueerDoc.

_____ (initial here)

I understand that I have received, reviewed, understand, and will comply with the policies and procedures explained in this QueerDoc CONSENTS TO CARE, PRIVACY, AND FINANCIAL AGREEMENT.

I understand that this agreement may be reassessed or amended by QueerDoc periodically.

I understand that a copy of this form will be kept in my medical chart and a copy may be furnished to me at my request.

Client Signature: _____ Date:_____

Print name: _____

Print legal/health insurance name: _____