River Valley Health
DIRECT CARE

FEE FOR SERVICE
MEDICAL AGREEMENT

Print Patient Name_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Cell Phone_____Email_____

I Agree to Text and email Communication:
- ☐ Yes
- ☐ No

Patient or Guardian: _____ Relationship to Patient: _____

1. Medical Consent: I consent to any medical treatments or procedures which may be performed on an outpatient basis (excluding emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of **River Valley Health** assisting my care.

2. Financial Obligation: I understand that all **Fee For Service (FFS)** charges are due at the time of service. I agree to pay **River Valley Health** for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. The **Fee For Service charges are as follows**:

- ☐ Acute Visit $120
- ☐ Regular Visit $120
- ☐ Follow up check $80
- ☐ TELEMEDICINE $80
- ☐ Antigen Test $110
- ☐ NAAT test $150
- ☐ RT-PCR test $170
- ☐ Blood Draw $20
- ☐ Ear Lavage x1 $80
- ☐ Ear Lavage x2 $100
- ☐ Toenail Removal x1 $200
- ☐ Toenail Removal x2 $250
- ☐ Onsite EKG $80
- ☐ Laceration Repair $200

- ☐ IV start + Hydration $80
- ☐ Wellness visits $120
- ☐ Weight loss Visit $120
- ☐ Sports Physicals $20
- ☐ Onsite Blood test (complete metabolic panel, cholesterol) $50
- ☐ Onsite Urine test $20
- ☐ Onsite A1C $50
- ☐ Onsite Blood Glucose $20
- ☐ Onsite pregnancy test $20
- ☐ Onsite Drug Screen $80
- ☐ Suture or Staple removal if placed somewhere else $50 (If placed at RVH is free)

- ☐ D3 Injection $40
- ☐ B12 injection $40
- ☐ Testosterone Injection$ 60
- ☐ Onsite oral Rx each $5
- ☐ Onsite Inhaled Rx $10
- ☐ Onsite Injection Rx $40
- ☐ Onsite Topical Rx $50
- ☐ Onsite IV Rx $60
- ☐ Onsite IV fluids liter $75
- ☐ Wellness Regular IV $150
- ☐ Wellness IV add-ons $40
- ☐ Meyers Cocktail $200
- ☐ Chelation Therapy $250
- ☐ **Other IV**_____ **$**_____
- ☐ **Other Tx**_____ **$**_____
- ☐ **Other Rx**_____**$**_____

3. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service.

4. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor. As such, we will not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

5. **Medicare.** The Patient understands that the Practice and staff have **opted out of Medicare**. As a result, both the Patient and the Practice shall be prohibited by law from seeking reimbursement from Medicare for any Services provided under this Agreement.

6. Release of Medical Information: I hereby authorize **River Valley Health** to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.

7. The undersigned certifies that he/she has read and agree to the above and foregoing, and received a copy thereof, and is the duly authorized to enter this FFS agreement.

Patient Name: _____

Date of Birth___/___/___

Patient or Guardian Signatures: _____Date: _____