EBO MD

OFFICE POLICIES AND PROCEDURES-CAPE GIRARDEAU PUBLIC SCHOOLS

INSURANCE: We do not bill insurance for any other services than laboratory services. Patient must make staff aware that they desire their insurance to be billed or the charges incurred will be added onto the patient account. If the patient has health insurance we ask that a copy of the cards stay on file with us for purposes of referrals to specialists and procedures that are done out of office.

FEES CHARGED: The monthly medical services membership fee is $50.00 per adult ages 26 and up and $10.00 per dependent under the age of 26 on the adult account. If there is no adult on the account, the patient will be billed $50.00 monthly regardless of age. Once a dependent on an account turns 26, there will be a 30 day grace period of which the charge will remain $10.00 per month, after the 30 days the patient will be charged an adult membership fee of $50.00. The medical services fee covers unlimited office visits and access to our medical staff via phone, skype, text, and e-mail as well as the MDVirtualCare membership. Medications dispensed, lab work, and injections are offered to our patients at discounted prices, however, they are not included in the monthly fee. Upon signing a membership contract with EBO MD, the patient will be responsible for a total of three months of services from EBO. This applies even if the patient decides to cancel before the third month's payment. The first month's payment will be charged on the day the patient signs up as a member, and will not be pro-rated. Thereafter, the monthly fee will be charged on the day chosen for auto withdraw.

PAYMENT POLICY: Payment for monthly medical services is due once each month, either on the 1st or the 15th of every month depending on which day the patient chooses. For these services, a credit or debit card or bank account information must be on file with EBO, along with the choice of an auto charge date of either the 1st or the 15th. Payment for labs, medications, and injections is due at time of service. In the event of a late payment, the patient will be charged an extra $25.00 per person, on the day after payment is due unless prior arrangements have been made with the office. This fee will be added to the patient's account. EBO MD reserves the right to re-try any credit/debit/bank accounts if the payment has failed on the day of the auto charge until the payment is made. In the event of a payroll deduct, the member will have the amounts taken out of their payroll as advised by their employer.

CANCELLATION: If a patient desires to cancel their membership with EBO MD, they agree to give a 30 day notice of when they would like to cancel. The patient will be responsible for the payment of the last 30 days. If a patient decides to return to EBO MD after cancelling the membership, they will be charged a $250.00 re-instatement fee to have their chart and records un-archived.

MDVirtualCare: Telehealth services are available to every patient at no extra cost to membership. This gives patients 24/7 access to non-emergent care for after hour office times and holidays. Upon becoming an EBO MD member, patients will receive a welcome e-mail from noreply@mdvirtualcare.com and are responsible for registering with them. EBO MD will automatically send member's demographic information to MDVirtual Care upon enrollment, unless patient requests otherwise in writing. If the patient has any questions or needs assistance with access, they can contact the office staff during regular business hours.

Responsible party Signature: _____ **Date**: _____

Member Information

1. Name(first and Last) _____ DOB: _____

Home Address _____

Cell Phone Number: _____Phone Number 2_____

Patient Gender: Male Female (please circle) Emergency Contact_____ (name and phone number)

Email _____@_____

2. Name(first and last) _____ DOB: _____

Home Address _____

Cell Phone Number: _____Phone Number 2_____

Patient Gender: Male Female (please circle) Emergency Contact_____ (name and phone number)

Email _____@_____

3. Name(first and last) _____DOB: _____

Home Address _____

Cell Phone Number: _____Phone Number 2_____

Patient Gender: Male Female (please circle) Emergency Contact _____ (name and phone number)

Email _____@_____

**********Please list Additional members on the back**********