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CONSENT TO TREAT AND FINANCIAL AGREEMENT

Consent to Treat. You, for yourself, or as a personal representative of the patient, voluntarily consent to all medical treatment and health care-related services that the caregivers at our Clinic consider to be necessary for the patient. You understand that caregivers include physicians, technicians, nurses, and other qualified personnel, which may also include appropriately supervised students and residents, who shall perform services and procedures as may be necessary in accordance with the judgment of the attending medical provider(s). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If you want any HIV testing to be performed anonymously, you will tell the caregiver. You understand that the patient's medical information may be shared with other providers who are involved in the patient's care and treatment, and you consent to such disclosure. The patient's lab samples may be used to perform routine quality assurance testing. You are aware that the practice of medicine and surgery is not an exact science; no guarantees have been made about the results of treatments or examinations.

Medical Photography. You acknowledge that a copy of the patient's photograph ID may be taken for Chart identification and documentation purposes for the patient's electronic health record and is the property of Clinic unless consent is withdrawn in writing. If treatment requires medical photography (e.g., photographs, videos), you consent to such medical photography and consent to the use of these photographs and any other records for medical care and medical documentation purposes.

You understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. You also understand it is your responsibility to assure those accompanying the patient comply with this requirement.

Financial Agreement

Financial Responsibility. You agree to the following:

- (a) Subject to applicable law and the terms and conditions of any applicable contract between Clinic and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient, you will be financially responsible and obligated to pay Clinic for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.
- (b) Except as required by law, you assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer. You are responsible for providing accurate insurance

information at the time of service. If this is not done, the patient will be responsible for paying the full amount, except for services subject to payment under applicable state worker's compensation laws or where another guarantor is responsible by law. You are also financially responsible for any balance, including co-pays, deductibles, and non-covered services. You also agree to complete all necessary paperwork for claims to be paid by the patient's insurance company and accept full liability for all charges if payment is not made on behalf of the patient's insurance company.

- (c) Subject to applicable law, and in consideration of all health care services rendered or about to be rendered, you agree to be financially responsible and obligated to pay Clinic for the patient balances due.
- (d) Consent to Contact. You authorize the Clinic and all clinical providers who have provided care to the patient, along with any billing services, collection agencies or other agents who may work on their behalf, to make contact on the cell and/or other phone number provided using automated telephone dialing systems, text messaging systems, electronic mail, or other computer assisted technology to provide messages (including pre-recorded or text messages) about the patient's account, payment due dates, missed payments, information for or related to medical goods and/or services provided, and other health care information. You promise to notify the Clinic in writing within 30 days if the patient phone number(s) change and understand that the Clinic will continue to use the number provided unless a notice of change is provided. You give permission for the Clinic to communicate information to you via electronic mail and understand that such information may not be encrypted or secure. To the extent allowed by law, the Clinic will not be liable to you for any calls or electronic communications, even if information is communicated to an unintended recipient.

Assignment of Benefits/Third-Party Payers. In consideration of all health care services rendered or about to be rendered, you hereby assign to Clinic all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Clinic's regular and customary charges for the health care services rendered. You authorize such payments from applicable insurance carriers, third party payers, and other third- parties. A list of usual and customary charges is available upon request. You consent to any request for review or appeal by Clinic to challenge a determination of benefits made by a third-party payer.

Missed Appointment Notification. To provide optimal care to all our patients, we ask that you give us a 24-hour notice if you need to cancel a scheduled appointment. Multiple missed appointments negatively impact our practice and the healthcare we provide to our patients. Therefore, at the discretion of the Clinic, if the patient has more than three "no shows" within a twelve-month period, the patient may be subject to dismissal from our practice.

Acknowledgements

Receipt of Notice of Privacy Practices. You have received or have been offered a copy of the Notice of Privacy Practices which describes how the patient's health information may be used or disclosed by the Clinic. It is understood that this Notice is provided the first time the patient receives services and then only when a significant change is made. Otherwise, it is available by request or on the clinic's website.

Electronic Communication. You may also receive emails and text messages from us that will include updates on our clinic, general health news, and business updates. You can unsubscribe at any time using the link included on all emails.

California Consumer Privacy Rights Act. California residents can find California specific data privacy information at [Vituity's CCPA Privacy Policy](http://www.vituity.com) at www.vituity.com. The policy informs you of the categories of Personal Information that we collect and the purposes for which those categories of Personal Information are used.

Open Payments Database. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. This database can be found at <https://openpaymentsdata.cms.gov>

Receipt of Copy of this Consent and Financial Agreement. You have received a copy of this fully signed and dated form and a copy will be retained in the patient's medical record maintained by the Clinic.

By signing this consent, the patient or their personal representative has read and understands this form and accepts its terms and conditions, and that it is being signed by the patient or the patient's authorized representative.

TELEHEALTH CONSENT

Overview of Telehealth.

Telehealth is a way to visit healthcare providers involving the use of electronic communications. You can talk to your provider from any place, including your home, without going to a clinic or hospital. Providers may include urgent care practitioners, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include live two-way audio and video and other materials (e.g. medical records, data from medical devices). By signing below, you consent to engaging in telehealth with your provider.

Your Rights.

You understand that you have the following rights with respect to my visit:

- You have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, you understand that the information disclosed by me during the session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or self; and where you make my mental or emotional state an issue in a legal proceeding. You also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without your written consent.
- You understand that my healthcare information may be shared with other individuals for treatment and healthcare operations purposes.
- You understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. In addition, you understand that telehealth-based services and care may not be as complete as face-to-face services. You also understand that if my provider believes you would be better served by face-to-face services, you may be referred to a provider who can provide such services.
- You understand that you may benefit from telehealth but that results cannot be guaranteed or assured.
- You understand that you have a right to access my medical information and copies of medical records in accordance with state law.
- You understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in your community.

Receipt of Copy of this Consent and Financial Agreement. You have received a copy of this fully signed and dated form and a copy will be retained in the patient's medical record maintained by the Clinic.

By signing this consent, you or your personal representative have read and understand this form and you accept its terms and conditions.

VITUITY
NOTICE OF PRIVACY PRACTICES (NPP)
FORM 13.G.1.

Your Information. Your Rights. Your Choices. Our Responsibilities

Vituity ® (Vituity is the trade name for CEP America, LLC and each of its member partnerships and subsidiaries) This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Get a copy of this privacy notice
- Get a list of those with whom we have shared your information
- Correct your paper or electronic medical record
- Ask us to limit the information we share
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information with family and friends about your condition.

Our Uses and Disclosures: We may use and share your information as we:

- Treat you
- Do research
- Comply with the law
- Work with a coroner, medical examiner, or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Respond to lawsuits and legal actions

We will not market or sell your health information.

Your Rights

When it comes to your health information, you have certain rights. This next section explains in more detail your rights, choices, and responsibilities, and our uses and disclosures of your information.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (and “accounting of disclosures”) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the contact information below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choice

You can tell us your choices about what we share with your family, close friends, or others involved in your care. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

To treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

To bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

To help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence

To do research

We can use or share your de-identified information for health research. De-identified information means information which does not reveal your identity.

To comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

To respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

To work with a coroner, medical examiner, or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

To address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- With health oversight agencies for activities authorized by law
- For law enforcement purposes or with a law enforcement official
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site, Vituity.com.

Compliance Contact Information You may:

- Reach our Compliance Team at compliance@vituity.com
- Contact our Chief Compliance and Privacy Officer, Emily Wang Zahn, JD, by email at emily.zahn@vituity.com or by phone at 209-484-0112.
- Anonymously report a violation through our toll-free hotline 24/7 at 1-877- 3ETHICS (1-877-338-4427)

Effective Date of this Notice: November 14, 2022.

