Auria Medical Clinics Policies including:

1-Financial policy

2-Practrice procedures and policies

3-HIPA policy

Effective 3/1/2021

We ask that all our patients read, understand, and accept our Policies if they agree, as described below. By completing, signing and submitting the registration form, I consent that I read, understand and agree with the following policies. I had the opportunity to reach the practice to ask any questions if necessary, for clarification of the following policies. I can download a copy of these policies on line and keep in my records.

1-Financial Policy

For your convenience, we accept all the following methods of payment:

-Check (with photo identification), There would be a $50.00 charge if the check bounces back.

-Visa, Master Card, Discover Card, American Express, Debit card

-Cash

Full payment is due at the time of service unless we have pre-approved your insurance coverage and accepted the assignment. Any required copays or deductibles owed by you will be collected at the time of service. If your insurance plan determines a service not to be covered, we will bill you for that charge, and you will be responsible to pay the charge.

Medicare beneficiaries are responsible for paying an annual deductible and 20% or more coinsurance if applicable.

If we do not have a contract with your insurance carrier, we cannot accept an assignment to be reimbursed by your carrier. Therefore, charges are due and payable by you at the time of service. You receive a receipt to submit to your insurance as you will.

It is the responsibility of the patient to check if the practice is in the network of her/his insurance if the patient uses the practice services out of her/his insurance network, the patient will pay the full charge for services.

We will bill your health plan for any hospital services we provide.

You will be responsible to pay any billed amounts upon receipt of a statement from our billing office. If you fail to pay the balance due up to three-time, each two weeks apart, the practice reserves the right to submit your debt to a collection agency.

If the patient has a guardian or chaperone, that person or entity is financially responsible for our charges.

If you fail to notify our office of cancellation 48 hours (or more) prior to a scheduled appointment, we reserve the right to charge your account a $35.00 no-show fee.

I have read and agree to the terms of the financial policy described above.

2- PRACTICE PROCEDURES AND POLICIES

Important practice procedures and policies

I UNDERSTAND THAT I HAVE TO ALLOW AT LEAST 72 HOURS FOR PRESCRIPTIONS TO BE REFILLED.

I UNDERSTAND THAT A FOLLOW-UP VISIT MAY BE REQUIRED FROM MY PHYSICIAN IN ORDER TO OBTAIN ADDITIONAL REFILL(S) OF MY MEDICATION (S PRESCRIPTIONS: I AGREE TO TAKE ALL MEDICATION(S) EXACTLY AS INSTRUCTED. I UNDERSTAND I AM NOT ALLOWED TO CHANGE THE DOSAGE AMOUNTS OR ALTER THE TIME SCHEDULE OF TAKING THE MEDICATION(S) WITHOUT FIRST SPEAKING TO MY PHYSICIAN. I UNDERSTAND THAT NARCOTICS MEDICATIONS WILL NOT BE CALLED IN AFTER HOURS, HOLIDAYS, OR ON WEEKENDS.

I MUST KEEP ALL APPOINTMENTS AS RECOMMENDED, IF ANY PATIENT DOESN'T SHOW UP FOR HER APPOINTMENT UP TO THREE TIMES WITHOUT PRIOR NOTICE TO CANCEL THE APPOINTMENTS, THE PATIENT IS RESPONSIBLE TO PAY FOR NO SHOW FEE AND THE PRACTICE RESERVES THE RIGHT TO DISCHARGE THE PATIENT FROM PRACTICE.

I understand that Auria Medical Clinics policy requires at least 48 hours to cancel or reschedule a follow-up or test appointment, not compliant with this request may generate a charge and I will be responsible for the current NO SHOW fee.

INSURANCE: I AM WELL AWARE THAT I AM RESPONSIBLE TO COMPLY WITH MY INSURANCE COMPANIES REGULATIONS REGARDING REFERRALS OR PRE-AUTHORIZATION, OTHERWISE I WILL BE RESPONSIBLE FOR PAYMENT IN FULL. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY CO-PAYMENT DUE AT THE TIME OF SERVICE AND/OR ANY OTHER AMOUNT NOT COVERED BY MY INSURANCE COMPANIES. HEREBY I ATHOURIZE THE AURIA MEDICAL CLINICS TO

RELEASE THE NECESSARY INFORMATION TO INSURANCE COMPANIES AS NEEDED, TO OBTAIN PAYMENT.

FOR MEDICAL SERVICE CHARGES. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

RETURNED CHECK: I IAM AWARE THAT THERE WILL BE A $50.00 FEE FOR ANY CHECK RETURNED BY MY FINANCIAL FACILITY.

COLLECTIONS: IN THE EVENT MY ACCOUNT IS SENT TO A COLLECTION AGENCY, ANY CHARGES OR LEGAL FEES GENERATED FROM THIS ACTION WILL BE ADDED TO MY BALANCE.

TERMINATION:

A PATIENT MAY BE DISCHARGED FROM THE PRACTICE WITH 30 DAYS NOTICE FOR NONCOMPLIANCE.

THE FOLLOWING ARE CONDITIONS FOR IMMEDIATE TERMINATION OF THE PRACTICE:

1-OBTAINING NARCOTICS FROM ANY OTHER PHYSICIAN WHILE UNDER OUR PHYSICIAN'S CARE ALTERING OR FORGING OF A PRESCRIPTION WHICH IS CONSIDER A FEDERAL FELONY AND WILL BE REPORTED TO THE AUTHORITIES.

2- USING INAPPROPRIATE LANGUAGE OR BEHAVING VIOLENTLY OVER THE PHONE OR IN THE OFFICE.

I have read and fully understood, and agree with the policies mentioned above.

3- HIPA PRIVACY POLICY

Notice of Privacy Practices

AURIA MEDICAL CLINICS, LLC

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.

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure.

We must follow the practices described in this Notice, but we can change our privacy practices and the terms of this Notice at any time.

If we revise the Notice, you may read the new version of the Notice of Privacy Practices on our website at [insert web address of Covered Department]. You also may ask for a copy of the Notice by calling us at [insert phone number of Covered Department] and asking us to mail you a copy or by asking for a copy at your next appointment.

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent

We may use and disclose your Protected Health Information as follows without your permission:

For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays.

To obtain payment. We may disclose your health information in order to collect payment for your health care. For instance, we may release information to your insurance company.

For health care operations. We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.

When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.

For activities related to death. We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.

For studies. In order to serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by UWM's Institutional Review Board or a special privacy board. In most cases, your information will be used for studies only with your permission.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. In certain situations, we may disclose health information of military officers and veterans, to correctional facilities, to government benefit programs, and for national security reasons.

For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.

For fundraising purposes. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving any such communications by contacting our Privacy Officer (listed below) and your decision to opt-out will have no impact on your treatment.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object

In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object:

In patient directories. Your name, location and general health condition may be listed in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religion may be shared with clergy.

To your family, friends or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

For research purposes. In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment.

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or

call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took the notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

Your Rights Regarding Your Protected Health Information

You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by

us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. UWM will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you., We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will give you a paper copy of this Notice.

If you have any questions about these rights, please contact us.

How to Complain about Our Privacy Practices

If you think we may have violated your privacy rights, or if you disagree with a decision, we made about your Protected Health Information, you may file a complaint with our Privacy Officer by writing to [contact information].

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington, D.C. 20201 or by calling 1-877-696-6775.

We will take no action against you if you make a complaint to either or both of these persons.

How to Receive More Information About our Privacy Practices

If you have questions about this Notice or about our privacy practices, please email us at info@auriaclinics.com

Effective Date

This Notice is effective on March 1, 2021

By signing here, I consent that I agree with all the above-mentioned policies.

Print: Sign: Date: