Consent for Treatment
Internal Medicine Associates of Plano, PLLC (IMAP)
Doctors of Internal Medicine, PLLC (DIM)

Consent for Treatment by IMAP/DIM

I hereby authorize IMAP/DIM through its providers to perform exams, tests, procedures, and any other care deemed necessary or advisable for my diagnosis and treatment. I understand that this consent to treat will be valid for each visit I make to IMAP/DIM until revoked by me in writing.

Consent for Telehealth Treatment by IMAP/DIM

Telehealth involves either the real-time, interactive audio and video evaluation of a patient by a provider (synchronous telehealth) or the submission of information by a patient to a provider (such as messages regarding symptoms, images, or other health information) that they may use to provide diagnosis, care, and treatment to the patient (asynchronous telehealth). Telehealth allows me to see a provider and/or receive care without coming into the office.

If I choose to make a telehealth appointment, I understand that:

- The same standard of care will apply to my care and treatment as if I attended an in-person visit. If a provider determines that they cannot perform an adequate examination of me via telemedicine, the appointment may be discontinued and I will be asked to reschedule for an in-person visit.
- There is a risk of technical difficulties (such as poor connection or technical malfunction) that may result in the need to discontinue the visit and reschedule for an in-person visit.
- An in-person visit may be required in order to obtain prescriptions for controlled substances.
- I can request the telehealth visit be stopped at any time. If I do so, the visit will be terminated and the termination will be documented in my medical record. I also understand that my choice to terminate the visit will not affect my right to future care or treatment.
- Health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- The same patient privacy rights will apply to my information as if I attended an in-person visit.

By Signing below, I confirm that I have read and understand the above Consent for Treatment.

Patient Name (Print): _____

Patient/Parent or Guardian Signature: _____ Date: _____

Patient Registration
Internal Medicine Associates of Plano, PLLC (IMAP)
Doctors of Internal Medicine, PLLC (DIM)

Patient Information:

Name: _____ DOB: _____ Age: _____

Address: _____ City, ST Zip: _____

SSN #: _____ Sex: _____ Marital Status: _____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Occupation: _____

Responsible Party (if different from patient information above):

Name: _____ DOB: _____ Age: _____

Address: _____ City, ST Zip: _____

SSN #: _____ Sex: _____ Marital Status: _____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Primary Insurance:

Name of Insurance: _____ Type (HMO/PPO/POS/etc.): _____

ID #: _____ Group #: _____

Effective Date: _____

Secondary Insurance (if applicable):

Name of Insurance: _____ Type (HMO/PPO/POS/etc.): _____

ID #: _____ Group #: _____

Effective Date: _____

How did you hear about us:

☐ Newspaper/Magazine Ad ☐ Internet Search

☐ Social Media/Facebook ☐ Clinic Website

☐ Family/Friend Name _____

☐ Referring Physician Name _____

☐ Other _____

Patient Financial Responsibility Policy & Assignment of Benefits
Internal Medicine Associates of Plano, PLLC (IMAP)
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PATIENT FINANCIAL RESPONSIBILITY

Payment is required for all services at the time they are rendered. As a courtesy we will file your claim with your insurance carrier. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected. Once our office has received an Explanation of Benefits from your insurance, and the provider adjustments have been applied, you will receive a statement for any outstanding balance, which is due upon receipt.

We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (to the extent of the visit amount) are due at the time of service. We will only file secondary claims when Medicare is the primary insurance. If there is no secondary insurance, patient will be responsible for appropriate co-insurance at time of service.

We will file insurance claims using all valid and current information provided by the patient. If you have an HMO or policy that requires a PCP to be assigned, ***You*****, as the patient must designate the physician you are seeing in this office to be your Primary Care Provider (PCP)** ***prior*** **to your first office visit/appointment and confirm that they are in-network with your insurance.** The assignment of the PCP must be effective the day services were rendered (or beforehand). If you have not assigned our physician as your PCP, you will be self-pay and agree to be responsible to pay the entire balance for your visit. If you would like to meet with the physician prior to choosing him or her as your PCP, the visit will be self-pay and you will have to assume full responsibility for the amount of that visit as your insurance will not cover the visit until PCP status has been assigned by you.

RETURNED CHECK POLICY

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, although this is not a guarantee of payment until your insurance has processed the claim.

There will be a thirty ($30.00) fee charged for any returned check. This fee is charged even if the check is re-deposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the forms of cash, money order, Visa, MasterCard, American Express, or Discover. If payment is not received by the due date indicated on the bill, then your information will be turned over to the Collin County District Attorney. After receiving a returned check, we will no longer accept checks as a form of payment on your visits for up to five years.

LATE FEES

For all account balances in excess of 90 days past due, a late fee of 10% of the outstanding amount will be added to the balance. The account will be turned over to our collection agency if payment is not received 15 days after notification that the account is 90 days past due. It is ultimately the patient's responsibility to make sure that IMAP/DIM receives payment for services rendered.

LATE CANCELLATION/NO-SHOW FEE

Patients who do not cancel or reschedule their appointment at least 24 hours prior to their scheduled visit will be charged a fee of $50.00 as permitted by law. This fee also applies to any patients that do not show up for their scheduled appointment. Excessive no shows and/or late cancellations could be grounds for termination from IMAP/DIM.

OVERPAYMENT REFUND POLICY

Any overpayment made by a patient will be processed as a refund to the patient within thirty (30) days after the date it is determined that an overpayment has been made.

PRECERTIFICATIONS/REFERRAL AUTHORIZATION (when required by your insurance)

Precertification of Hospitalization: IMAP/DIM must be notified within 24 hours of any hospital admit so that we may pre-certify your hospital visit/stay. Failure to do this may result in reduction of benefits. We will not be responsible for any reduction of benefits if this is not done.

Referrals: Due to the tremendous amount of referral requests, we must be notified at least five (5) business days prior to your appointment with the specialist in order to provide the formal referral necessary for that provider. Patients who see specialty care providers first and then call after the fact to request a referral number run the risk of reduction of benefits as most insurance companies do not back-date referrals. We will not be responsible for any reduction of benefits due to "after-the-fact" referral requests. When referred, it is the patient's responsibility to verify that the physician or facility is in their insurance network.

QUESTIONS, COMPLAINTS, AND CONCERNS RELATED TO BILLING OR THIS POLICY

It is our goal to ensure that any questions, complaints, and concerns about your medical bills, our billing processes, and this policy are addressed in a timely and transparent manner. Any questions related to your bill, our billing policies, and this policy may be addressed to billing@planointernist.com.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION FOR PAYMENT PURPOSES

- I authorize IMAP/DIM to disclose and release my medical and treatment information to my insurance carrier(s) and their authorized agents for payment and claims processing purposes for services rendered by IMAP/DIM.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare & Medicaid Services, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed.
- I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I authorize IMAP/DIM and its authorized agents to act as my agent for purposes of obtaining payment from my insurance carrier(s).
- I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance, including all medical benefits for office visits and procedures plan(s) directly to IMAP/DIM and their respective Physician Assistants, Nurse Practitioner and all care team providers employed by the group.
- I understand that I am financially responsible for charges not covered by my insurance carrier(s) and have received a copy of IMAP/DIM's Patient Financial Responsibility Policy.
- This assignment of benefits will remain in effect until revoked by me in writing.
- A photocopy of this document will have the same validity as the original.

By signing below, I confirm that I have read this Patient Financial Responsibility Policy and understand the provisions outlined therein. I agree to be responsible for any balance present on my account, including any charges for services that are not covered by insurance, late fees, returned check fees, or late cancellation/no-show fees. If my insurance denies payment because the provider was not assigned as my PCP at the time of service, I will assume full responsibility for the charges incurred for that visit and will pay in full. I agree to assign my benefits as outlined above, and to the release of my medical and treatment information for payment purposes as described above.

Patient Name (Print): _____

Patient/Parent or Guardian Signature: _____ Date: _____

Technology & Artificial Intelligence (AI) Policy
Internal Medicine Associates of Plano, PLLC (IMAP)
Doctors of Internal Medicine, PLLC (DIM)

IMAP/DIM utilizes various forms of technology to communicate with you about your care, to assist with the documentation of your care, and to ensure your safety while visiting IMAP/DIM. Below is a description of some of the ways we use technology in our practice to provide you with safe, efficient, and modern care while ensuring patient privacy and confidentiality.

VIDEO SURVEILLANCE OF THE BUSINESS/PUBLIC AREAS OF THE OFFICE

IMAP/DIM uses video surveillance of the business/public areas for the protection and safety of all the patients and staff. There is NO recording or surveillance in patient exam rooms and restrooms.

USE OF ARTIFICIAL INTELLIGENCE (AI)

IMAP/DIM uses Artificial Intelligence (AI) technology to assist with documentation of your care. This includes the use of AI tools to assist with your diagnosis and treatment. All use of AI technologies by IMAP/DIM is done in accordance with state and federal law, as well as standards adopted by the Texas Medical Board. All providers are required to review any information generated by AI tools for accuracy before this information can be incorporated into your medical record, before any diagnosis is made, and before any course of treatment is recommended. All information collected, generated, or stored related to IMAP/DIM's AI use is governed by IMAP/DIM's Notice of Privacy Practices.

USE OF AMBIENT AI

Providers at IMAP/DIM may use "Ambient AI" in exam rooms. This involves the audio recording of visits that are then interpreted by artificial intelligence software to assist in documentation of your care by generating a summary of the visit that is then reviewed, modified, and corrected by your provider as necessary before it is incorporated into your medical record. As discussed above, all use of AI technologies by IMAP/DIM is done in accordance with state and federal law, as well as standards adopted by the Texas Medical Board. All providers are required to review any information generated by AI tools for accuracy before this information can be incorporated into your medical record, before any diagnosis is made, and before any course of treatment is recommended. All information collected, generated, or stored related to IMAP/DIM's AI use is governed by IMAP/DIM's Notice of Privacy Practices. You may opt out of the use of Ambient AI at any time, and doing so will not affect the quality of care you receive.

USE OF PHOTOGRAPHY AND VIDEOS IN MEDICAL RECORDS

In connection with your treatment, photos or videos may be taken and included in your medical record to assist us in evaluating and documenting your condition. The privacy of these photos and videos is governed by IMAP/DIM's Notice of Privacy Practices.

USE OF TELEPHONE NUMBERS AND ELECTRONIC MEANS OF CONTACT

We may use secure messaging through the patient portal, secure text/SMS messaging, or phone calls to contact you regarding your care. Some phone calls may be automated, prerecorded, or use an artificial voice. Similarly, some text/SMS messages may be automated. We will only contact you using contact information you have provided to us. Though we use secure text/SMS messages and a secure portal, voicemails and text messages can be intercepted and we cannot guarantee the security of your voicemail or text/SMS inbox, therefore please only provide phone numbers you are comfortable with us leaving

detailed messages regarding your health. You may change your preferred phone number(s) for receipt of detailed health information at any time by updating your contact information within the patient portal.

USE OF UNSECURED EMAIL

We do not use a secure, encrypted outgoing email program to correspond with patients. Therefore, if you wish to receive emails from IMAP/DIM or to correspond with IMAP/DIM via unsecure email, it is important to be aware that these emails will not be encrypted and may be intercepted. Therefore, please only provide us with email addresses at which you are comfortable with receiving unsecured, unencrypted emails regarding your health. You may change your preferred email address(s) for receipt of detailed health information at any time by updating your contact information within the patient portal.

PATIENT PORTAL

Please sign up for our patient portal today! Our portal gives you access to your healthcare data (medication list, laboratory results and medical summary) and most importantly you can communicate with us through the secure portal system. You can ask questions or refill your medications through the portal. Please be advised that the patient portal should not be used for emergencies, as it may take up to three (3) business days to answer your request. Please note that lab and diagnostic tests results usually take at least two (2) business days to become available in the patient portal. You may call IMAP at (972) 468-9999 or DIM at (972) 758-4455 if you require a timelier response, and such calls should be returned within one (1) business day. In the event of a medical emergency, please call 911.

TECHNOLOGY POLICY ACKNOWLEDGMENT AND CONSENT TO USE OF TECHNOLOGY

By signing below, I acknowledge that:

- I have read and understand IMAP/DIM's Technology and Artificial Intelligence (AI) Policy.
- I agree to the use of photography and videos in relation to my care and treatment.
- I agree that IMAP/DIM may contact me using the phone numbers listed below, as well as those included in and/or connected to the patient portal and leave detailed messages regarding billing, scheduling, my health, and my test results.
- I agree to electronic communication regarding my care as described above through the patient portal and secure text/SMS messaging.
- Unencrypted Email:
  - ☐ I understand that emails between myself and IMAP/DIM may not be encrypted or secure and that, by providing my email address below, I acknowledge the risks associated with this method of communication.
  - ☐ I do not agree to the use of Unencrypted Email.
- Ambient AI:
  - ☐ I agree to the use of Ambient AI, which includes audio recording of my visits. I understand that I have the choice to opt out of Ambient AI, and that doing so will not negatively impact the quality of care that I receive.
  - ☐ I do not agree to the use of Ambient AI.
- This authorization will remain in effect until revoked by me in writing.

Patient Name (Print): _____

Patient Phone #: _____ Alternate Phone #: _____

Patient Email: _____

Patient/Parent or Guardian Signature: _____ Date: _____

Authorization to Discuss My Information & Emergency Contact
Internal Medicine Associates of Plano, PLLC (IMAP)
Doctors of Internal Medicine, PLLC (DIM)

Authorization to Discuss My Health Information with Family, Friends, or Other Individuals

If you would like to authorize us to discuss your health information or aspects of your care with any friends, family members, or loved ones, please complete the contact information below and select the relevant boxes regarding information to be shared with the authorized individual(s).

Name (Print): _____

Phone #: _____ Relationship: _____

☐ Appointments/Scheduling ☐ Test Results

☐ Billing/Insurance ☐ Treatment/Medical Information

☐ All medical information, including but not limited to appointments, billing, test results, diagnosis, and procedures.

Name (Print): _____

Phone #: _____ Relationship: _____

☐ Appointments/Scheduling ☐ Test Results

☐ Billing/Insurance ☐ Treatment/Medical Information

☐ All medical information, including but not limited to appointments, billing, test results, diagnosis, and procedures.

Name (Print): _____

Phone #: _____ Relationship: _____

☐ Appointments/Scheduling ☐ Test Results

☐ Billing/Insurance ☐ Treatment/Medical Information

☐ All medical information, including but not limited to appointments, billing, test results, diagnosis, and procedures.

Emergency Contact Information

Name (Print): _____

Phone #: _____ Relationship: _____

☐ Do not disclose any information on file other than to patient on record.

This authorization will remain in effect until revoked by me in writing.

Patient Name (Print): _____

Patient/Parent or Guardian Signature: _____ Date: _____

Notice of Privacy Practices

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.

Our employees may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by IMAP/DIM and is effective as of October 22, 2026.

We are committed to protecting patient privacy. We are required by the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this notice and to make sure that: your identifiable medical information is kept private; you understand our legal duties and privacy practices with respect to medical information about you; the terms of the notice that are currently in effect are followed; and you are notified in the event of a breach of any unsecured protected health information about you. 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.

Uses and Disclosures

We typically use or share your health information in the following ways:

- **Treatment –** 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.*
- **Payment –** 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.*
- **Healthcare Operations –** 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.*
- **Legal Requirements –** if required by law, such as reporting abuse, public health risks, workers' compensation claims, or responding to a court order.

Other Uses and Disclosures

We are allowed or required to share your information in other ways that contribute to the public good, such as public health and research. We are required to meet several conditions in the law before we can share your information for these purposes, which may include the following:

- **Public Health and Safety –** we can share health information for situations such as preventing disease, helping with product recalls, or reporting adverse reactions to medications.
- **Support Research –** we can use or share your information for health research.
- **Organ and Tissue Donation –** we can share health information about you with procurement organizations.
- **Medical Examiner or Funeral Director –** we can share health information with a coroner, medical examiner, or funeral director when an individual dies.

All other uses and disclosures require prior authorization. You have the right to receive a copy of the authorization and the right to revoke the authorization at any time.

Notice Regarding the Use of Technology

We may use electronic software, services, and equipment, including without limitation to email, video conferencing technology, cloud storage and servers, internet communication, cellular network, voicemail, facsimile, electronic health record, and related technology ("Technology") to share Protected Health Information (PHI) with you or third-parties subject to the rights and restrictions contained herein. In any event, certain unencrypted storage, forwarding, communications and transfers may not be confidential. We will take measures to safeguard the data transmitted, as well as ensure its integrity against intentional or unintentional breach or corruption. However, in very rare circumstances security protocols could fail, causing a breach of privacy or PHI.

Special Protections for Substance Use Disorder (SUD) Treatment Information

Certain health information related to substance use disorder diagnosis, treatment, or referral receives heightened protection under 42 CFR Part 2.

We may not disclose your SUD treatment information without your written consent, unless:

- A specific Part 2 exception applies, such as a medical emergency, certain research activities, mandated reporting of child abuse or neglect, or valid court orders: or
- Disclosure is permitted by both Part 2 and HIPAA, and no stricter protection applies.

Any consent you provide for disclosure of Part 2 information must satisfy specific federal requirements, including describing the information to be disclosed, the recipient, the purpose of disclosure, and your right to revoke consent.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to assist you.

- **Access to Records**
  - You may submit a written request to get an electronic or paper copy of your medical record and other health information we have about you.
  - 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.
- **Request Restrictions**
  - 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.
- **Confidential Communications**
  - You can ask us to contact you in a specific manner (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.
- **Amend Records**
  - You can ask us to correct inaccuracies in your health record. We may say “no” to your request, but we will tell you why in writing within 60 days.
- **Receive a Record of Disclosures**
  - You can ask for a list (accounting) of the times we’ve 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’ll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- 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.
- We never share your information in the following cases, unless you give us written permission: marketing purposes, sale of your information, or most sharing of psychotherapy notes.
- We may contact you for fundraising efforts, but you can tell us not to contact you again. If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.
- 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.

Complaints or Questions

If you believe your privacy rights have been violated, you may file a complaint with us by notifying our Privacy Officer, Stacey Aitken, at (972) 360-0060 or saitken@doctorsofplano.com, or by filing a complaint with the US Department of Health and Human Services Office for Civil Rights at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES

I have been given a copy of IMAP/DIM's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Privacy Officer.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Patient Name (PRINT)

_____ _____
Signature Date

_____
Personal Representative (PRINT) *if applicable*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency, it was not possible to obtain an acknowledgement.
- ☐ We were unable to communicate with the patient.
- ☐ Other (*Please provide specific details*):

_____

_____

_____ _____
Employee Signature Date