Patient Agreement

This Patient Agreement (Agreement) is between CARITAS PEDIATRICS AND WELLNESS, PLLC (the Practice, Us or We), and the person signing this Agreement ("You", Guardian) on behalf of your child(ren), or Patient.

The Practice, located at 300 BEARDSLEY LANE, BLDG E, SUITE 101-102, AUTIN TEXAS 78746, provides ongoing primary care medicine to its Patients using a Direct Primary Care model that comprises of both Direct Pay (Flat Fee) services as well as a Consultation Package Plan. In exchange for certain Fees (Flat Service Fee or Consultation Package Fee), The Practice agrees to provide You with the Services described in this Agreement under the terms and conditions contained within.

Definitions:

1. **Services.** In this Agreement, "Services" means the collection of services, medical and non-medical, which are described in Appendix A (attached and incorporated by reference), which We agree to provide to You under the terms and conditions of this Agreement.

2. **Patient.** In this Agreement, "Patient," "You" or "Yours" means the persons for whom the Practice shall provide care, who have signed this Agreement, and/or whose names appear in appendix B (attached and incorporated by reference).

3. **Term.** This Agreement will last for one year, starting on the date it is fully executed by the parties. NO PHYSICIAN-PATIENT RELATIONSHIP SHALL BE FORMED OR ANTICIPATED UNTIL THE AGREEMENT IS FULLY EXECUTED.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the Agreement unless either party cancels the Agreement by giving 30 days written notice.

5. **Termination.** Either party can cancel this Agreement at any time, for any reason, by giving 30 days' written notice to the other of intent to terminate. Reasons for Patient's dismissal from the Practice include, but are not limited to, threatening or disrespectful behavior toward the Practice staff or doctor(s), sharing the established patient-only phone number with non-established patients, and non-payment.

6. **Payments and Refunds.** Amounts and Methods.

A. In exchange for the Services described in Appendix A, You agree to payment for services rendered either in a Flat Fee (Direct Pay) or Consultation Package Fee (where applicable) in the amount which appears in Appendix C, which is attached and incorporated by reference;

B. Consultation Package Services- Unless You elect to pay the Fee in full, the Fee shall be divided into monthly payments and drafted on the first day of every month via debit or credit card or automatic bank draft. You agree to keep a current method of payment on file.

C. Declined payments will be considered late after 3 business days and will incur a $50 late fee. Unless other arrangements are made, Patients will be discharged after 60 days of non-payment (consecutive or cumulative in one calendar year).

D. Late Fee. A $50 fee will be charged to the card on file when a Patient cancels within 8 hours of their appointment, is greater than 15min late and has not called to inform the clinic of delay, or does not show up for the appointment without calling the clinic for rescheduling.

7. **Early Termination.** If You have paid the Consultation Package Fee fully or monthly and cancel this Agreement before its term ends, We will refund any unused portion of your Fee, beyond 30 days, on a per diem basis.

8. **Non-Participation in Insurance.** The Practice does not participate with any health plans, HMO panels, or any other third-party payor, whether private or government sponsored. As such, we may not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement, identified in Exhibit A.

9. **Medicaid.** The Patient understands that the Practice and staff are an ordering and referring physician only of Medicaid. The Practice does not bill or seek reimbursement from Medicaid. Patients who are Medicaid beneficiaries understand that they are joining the Practice under private contract. Therefore, You are responsible for Fees for services rendered and/or other Patient charges under this Agreement. Neither the Practice nor the Patient may submit to, or be reimbursed by, Medicaid for such charges. Prescriptions, lab testing, imaging, etc., ordered by Your Physician and filled by an outside entity may be submitted by the Patient to Medicaid for reimbursement consideration.

10. **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, even if the Services may be covered and payable by Medicare if rendered by a Provider who participates in Medicare. Accordingly, the Patient agrees not to submit bills or seek reimbursement from Medicare for the Services. Furthermore, if the Patient is eligible or becomes eligible for Medicare during the term of this Agreement, the Patient agrees to immediately inform the Practice and sign the Medicare private contract as provided and required by law.

11. **This Agreement Is Not Health Insurance.** The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff.

12. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement.

13. The Patient acknowledges that We have advised them to obtain health insurance that will cover catastrophic care and other services not included in this Agreement. Patients are always

personally responsible for the payment of any medical expenses incurred for services not included under this Agreement.

14. **Technical Failure.** Neither the Practice nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to the Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service; (ii) power outages; (iii) failure of electronic messaging software, or email; (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (iv) any interception of email communications by a third party which is unauthorized by the Practice; or (v) Patient's failure to comply with the guidelines for use of email or text messaging, as described in this Agreement.

15. **Physician Absence.** From time to time, due to such things as conferences, vacations, patient emergencies, Physician illness, or personal emergency, the Physician may be temporarily unavailable. When the date(s) of such absences are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled at the Patient's convenience. If during Physician's absence, the Patient experiences an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. Charges from Urgent Care or any other Outside Provider are not included under this Agreement and are the Patient's responsibility. The Patient may, however, submit such charges to their health plan for reimbursement consideration or request that the Outside Provider do the same. The Patient is responsible for understanding the coverage rules of their health plan, and We cannot guarantee reimbursement.

16. **Dispute Resolution.** Each Party agrees not to make any inaccurate or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized care to each Patient, but occasionally misunderstandings arise. We welcome sincere and open dialogue with our Patients, especially if We fail to meet expectations, and We are committed to resolving all Patient concerns. Therefore, in the event that a Patient is dissatisfied with, or has concerns about, any Staff Member, service, treatment, or experience arising from their establishment in this Practice, the Patient and the Practice agree to engage in the following process: A. Patient shall first discuss any complaints, concerns, or issues with Dr. Roeder, who may be contacted at 512-737-8780; B. The Practice shall respond to each of the Patient’s issues or complaints; If, after such response, Patient remains dissatisfied, the Practice and Patient agree to the following dispute resolution process: A. Mediation. Any disputes arising from or relating to this Agreement, including any professional liability claims against Practice or any of its contractors, agents, or employees, will first be submitted to mediation pursuant to the terms of the Agreement to Mediate of the American Health Law Association (“AHLA”). Mediation shall occur within thirty (30) days of the date on which either Party indicates its intent to mediate. B. Arbitration. If mediation is unsuccessful, the parties agree that any disputes arising from or relating to this Agreement, including any professional liability claims against Practice or any of its contractors, agents, or employees, will be adjudicated pursuant to the rules of the AHLA. This provision shall be read as broadly as possible to include the arbitration of any claim related to the

relationship between the parties. The arbitration shall be conducted in Travis County, Texas before a sole arbitrator. Notwithstanding any provision to the contrary, all costs of arbitration will be borne equally, subject to being reallocated by the arbitrator as part of the final award.

17. **Fees and Service Offering Adjustments.** In the event that the Practice finds it necessary to increase or adjust fees or Service offerings before the termination of the Agreement, the Practice shall give 30 days' written notice of any adjustment. If Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled visit.

18. **Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and the Practice is required to refund fees, the Patient agrees to pay the Practice an amount equal to the fair market value of the medical services Patient received during the time period for which the refunded fees were paid. The Parties agree that fair market value shall be the amount that the Practice would charge for the medical services in question if they were provided on a Fee for Service basis. The Practice shall maintain a list of Fee-For-Service charges which is available to Patients on request.

19. **Change of Law.** If there is a change of any relevant law, regulation or rule, which affects the terms of this Agreement, the Parties agree to amend it only to the extent that it shall comply with the law.

20. **Severability.** If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part shall be amended to the extent necessary to be enforceable, and the remainder of the Agreement will stay in force as originally written.

21. **Amendment.** Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the Parties.

22. **Assignment.** Neither this Agreement nor any rights arising under it may be assigned or transferred without the agreement of the Parties.

23. **Legal Significance.** The Patient acknowledges that this Agreement is a legal document that gives the Parties certain rights and responsibilities. The Patient agrees that they are suffering no medical emergency and has had reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and is satisfied with the terms and conditions of the Agreement.

24. **Miscellaneous.** This Agreement is to be construed without regard to any rules requiring that it be construed against the drafting Party. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

25. **Entire Agreement.** This Agreement contains the entire Agreement between the Parties and replaces any earlier understandings and agreements, whether written or oral.

26. **No Waiver.** Either Party may choose to delay or not to enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of that duty or responsibility and the Party shall retain the absolute right to enforce such rights or duties at any time in the future.

27. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Texas.

28. **Notice.** Written Notice for all matters except for notice of termination, may be achieved either by email or U.S. first-class mail. Notice of termination shall be provided via certified mail, return receipt requested, overnight service (FedEx, UPS), via courier or in person. Notice must be delivered to the Practice at the address first written above and to the Patient, at their address provided in Appendix B.

29. **Counterparts and Electronic Signatures.** This Agreement may be executed in any number of counterparts, all of which shall constitute one and the same instrument, and any Party to this Agreement may execute it by signing and delivering one or more counterparts. Each Party agrees that this Agreement and any of its related documents may be electronically signed. The Parties further agree that any electronic signatures appearing on this Agreement or its related documents are and shall be considered the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Communications:

The Practice endeavors to provide Patients with the convenience of a wide variety of electronic communication options. Although We are careful to comply with Patient confidentiality requirements and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed secure or confidential methods of communications. By placing Your initials where indicated, You acknowledge the above and indicate that You understand and agree that by initiating or participating in the above means of communication, You expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of establishment in this Practice; that You are not required to initial this clause; and that You have the option to decline any particular means of communication.

Initials of Patient or Patient's Caregiver:_____

Email and Text Usage:

By providing an email address on the attached Appendix B, the Patient authorizes the Practice and its Staff to communicate with him/her by email regarding the Patient's "protected health information" (PHI). By providing a cell phone number in Appendix B and agreeing to the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. The Patient further understands and acknowledges that:

A. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access.

B. If You do not receive a response to an e-mail or text message within 24 hours, You agree that You will contact a Physician by telephone.

C. **Email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information.** Therefore, in an emergency or a situation that could reasonably be expected to develop into an emergency, the Patient agrees to call 911 or go to the nearest emergency care facility and follow the directions of personnel. If You decide to contact the Physician by phone, You agree to call the Physician rather than text or email.

Initials of Patient or Patient's Caregiver:_____

Duration of Contract:

This Contract becomes effective on Date of Signing (unless otherwise specified). Either Party may terminate treatment with a 30-day notice to the other Party. Notwithstanding this right to terminate treatment, both Provider and Beneficiary agree that the obligation not to pursue Medicare/Medicaid reimbursement for items and services provided under this contract will survive this contract.

Authorization of Patient Agreement:

Patient/Parent/Guardian

Date

Relationship to Patient

Appendix A:

1. Medical Services

Medical Services offered under this Agreement are those consistent with the Physician's training and experience, and as deemed appropriate under the circumstances, at the SOLE DISCRETION OF THE PHYSICIAN. The Patient is responsible for all costs associated with any medications, laboratory testing and review of results by the Physician, specimen analysis and imaging related to these Services unless otherwise noted. Medical Services provided under this Agreement include the following:

- Well-baby/Well-child checks (required for ongoing care, scheduled set forth by the American Board of Pediatrics and American Academy of Pediatrics)
- Infant weight checks
- Acute and follow-up visits
- Sports and Camp physicals
- School physicals and forms
- Chronic Condition Management (e.g. asthma, eczema, allergies, obesity, etc...)
- ADHD evaluation and treatment
- Depression/Anxiety evaluation and management
- Concussion evaluation and management
- Injury evaluation and management
- Sports nutrition and injury prevention counseling
- Behavioral evaluation, counseling, and management
- Developmental Screening
- Vaccination discussions
- Nutrition and healthy lifestyle goal-setting
- Dipstick Urinalysis
- Urine collection via bag specimen (as indicated)
- Blood glucose testing
- Point-of-care Testing for bacterial and viral illness (e.g. Rapid Strep/Flu testing)
- Standard Vision screening
- Minor Wound repair (steri-strips, medical grade glue as appropriate), Minor foreign body removal (e.g. nose, ear, foot), Minor incision and drainage of abscess
- Umbilical granuloma treatment

- Medical Ear Piercing
- Lactation Services (for baby only)

2. Non-Medical, Personalized Services. The Practice shall also provide Patients with the following non-medical services:

• After-Hours Access. Subject to the limitations of paragraph 15 of the Agreement, Patient shall have direct telephone/text access to the Physician for guidance regarding urgent concerns that arise unexpectedly after office hours. Fees may be assigned for this service; see Appendix C. Phone calls and text messages after normal office hours may be upgraded to a virtual visit at the discretion of the Physician in order to provide the appropriate medical care for the situation.

• Text/Email Access. Subject to the limitations of paragraph 13 of the Agreement, The Patient shall be given Patient Portal access via the Electronic Medical Record to which non-urgent communications can be addressed. The Patient understands and agrees that neither email nor the internet should be used to access medical care in the event of an emergency or any situation that could reasonably develop into an emergency. The Patient agrees that in this situation, when s/he cannot speak to the Physician immediately in person or by telephone, to call 911 or go to the nearest emergency department and follow the directions of emergency medical personnel. The Physician may elect to convert text/email communications to phone or virtual visit on a case by case basis. Patient understands that text/email communications are deemed non-urgent and can be addressed on the next business day.

• Same Day/Next Day Appointments. When a Patient contacts the Practice prior to noon on a regular office day to request a same-day appointment, every reasonable effort shall be made to schedule the Patient for that same day. If a same day appointment is not possible, Patient shall be scheduled for the following office day (subject to the limitations of paragraph 14 of the Agreement).

• No Wait or Minimal Wait Appointments. Every reasonable effort shall be made to assure that the Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees more than a minimal wait time, Patient shall be contacted and advised of the projected wait time. Patient shall then have the option of seeing the Physician at the later time or reschedule at a time convenient to the Patient.

• Telehealth. Telehealth (virtual visits) will be available when desired and deemed appropriate by the Patient and Physician upon execution of the attached consent.

• Specialists Coordination. The Physician shall coordinate care with medical specialists and other practitioners to whom the Patient needs referral. The Patient understands that fees paid under this Agreement do not include specialist's fees or fees due to any medical professional other than the Practice staff

• Medication Refills. Please allow 24 hours for ALL medication refills. To ensure your child does not run out of their medication(s), please monitor their supply closely. For certain medications, such as those to treat ADHD and Asthma, your child may need to be seen before a refill can be authorized.

• Late Appointments. Patients arriving more than 15 minutes late for their appointment may be asked to reschedule; not calling to inform the clinic of late arrival will result in a $50 fee.

• No Show Policy. To help accommodate the needs of our Patients, and to be able to offer appointments to all Patients requesting our care, we charge a No-Show Fee of $50.00 per child per appointment scheduled with Dr. Roeder that is missed. After three “No Shows”, the Patient/family will be discharged from the Practice. An appointment is considered a no show if the appointment is not canceled or rescheduled at least 8 hours prior to the scheduled appointment time.

SERVICES NOT PROVIDED:

The Medical Providers at Caritas Pediatrics and Wellness do not prescribe or refer for any contraceptive agents (birth control pills, patches, rings, injections, intrauterine devices). Our Healthcare Providers do not perform or refer for abortion procedures. In addition to the above mentioned services and practices of Our Clinic, the Medical Providers do not practice and/or refer for any medications to halt puberty or provide cross-sex hormones.

By signing this consent, You are agreeing to receive medical care from Caritas Pediatrics and Wellness and understand that contraceptive services, abortive services and/or referrals,

and prescribing of puberty blockers and/or cross sex hormones and/or referrals for these medications are not available from our Healthcare Providers.

Authorization:

Patient/Parent/Guardian

Date

Relationship to Patient

Appendix B: Communication Preferences

I agree to text communications by Caritas Pediatrics:

Patient or Patient's Caregiver Initials:_____

I agree to email communications by Caritas Pediatrics

Patient or Patient's Caregiver Initials:_____

I agree to detailed voice messages being left at the number provided on patient's account:

Patient or Patient's Caregiver Initials:_____

Appendix C: Fee Itemization

WELLNESS VISIT FEE

Fee for wellness visit services rendered are $165 which includes clinic visit, developmental/behavior screen, assessment of vision and gross hearing, and growth parameters.

OFFICE VISIT/SICK VISIT FEE

Fee for office visit and/or sick visits is $150. In House labs are an additional charge, a list of these Fees is provided in clinic.

ACCESS TO PHYSICIAN VIA PHONE (OFFICE HOURS AND AFTER HOURS)

In the event Physician is contacted via phone and medical care or decision making is provided by the Physician, there is a fee of $50. Physician reserves the right to convert phone call to a virtual visit if necessary and Patient will be charged Fees designated for a Sick Visit.

CONSULTATION FEE

Where a Consultation is needed for root cause and in depth review of past medical history, nutrition/environmental assessments, vaccination adverse reactions, Fees for Consultation services including medical exemptions start at $350 and are determined by extent of review/workup or time. An Office or Sick Visit may be changed to a Consultation at the discretion of the Physician; the Physician will discuss this with the Patient at time of visit, if not before the scheduled appointment depending on severity or chronicity of symptoms during assessment.

CONSULTATION PACKAGE FEE

Where a Consultation package of designated duration is executed to tailor a treatment plan for a Patient's chronic illness or condition, at the discretion of the Physician, the follow fees are instituted:

3 months (including a maximum of 4 visits): $500

6 months (including a maximum of 7): $700

9 months (including a maximum of 10 visits): $900

TRUDOSE PLATELET RICH PLASMA (PrP) THERAPY SERVICES:

Where this specialized service is requested, the starting Fee for each therapy session is $1500 and includes a 1hr consultation at least 2wks prior to the service as well as a follow up visit which can be either in person or virtually. It is suggested that at least 4 therapy sessions are performed to have a significant benefit. PrP services are scheduled at least 80-90 days apart as recommended by TruDose. Suggestions for additional IV services at or around the time of TruDose will be provided and are not included in the PrP price; these additional Fees will be discussed at time of the service. Prices are subject to change and will be discussed prior to the consultation for PrP.

PAYMENTS

All Fees for services rendered will be collected at time of Office Visit or Consultation. Consultation package fees can be paid in full up front or divided up monthly. Declined payments will be considered late after 3 business days and will incur a $50 late fee. Unless other arrangements are made, Patients who have been delinquent on payments over a period of 60 days (consecutively or non-consecutively in a calendar year) will receive notice of termination.

CREDIT CARD PAYMENTS

All credit card payments will be subject to 2.5% credit card transaction fee.

By signing, I agree to the above fee schedule.

Signature of
Patient/Parent/Guardian:_____

APPENDIX D: **AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION**

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card information section below and sign the form. All requested information is required. Payments are made directly by our secure link accessed through our electronic health record; receipts for Physician services rendered will by sent to your email. Your statement will include service fees and incidental charges which you will receive prior to any payments or deductions.

Patient/Parent/Guardian:_____

PAYMENT INFORMATION

I understand and authorize Caritas Pediatrics and Wellness, PLLC automatic payments including Patient-Physician services fees (where applicable) and incidental fees as outlined in the Patient Agreement (late payment fee, no show/late cancellation fee, etc..).

CREDIT/DEBIT CARD INFORMATION:

Credit card type: **[_]** Visa, **[_]** MasterCard, **[_]** American Express, **[-]** Discover

_____ _____ _____/_____

Credit card number: Expires:

_____ _____

Cardholder's name: As shown on credit card CVC(Security code)

_____ _____

Customer's signature Date:

End billing when: Customer provides written cancellation

APPENDIX E: **ACH AUTHORIZATION**

I, _____, hereinafter called PATIENT/PARENT/GUARDIAN, hereby authorize Caritas Pediatrics and Wellness, PLLC., hereinafter called PROVIDER, to initiate debits and/or credits to or from my Bank Account indicated at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and or credit the same to such account. We acknowledge that the origination of ACH transactions to or from our account must comply with the provisions of U.S. law. **Please provide this originator number to your bank account so that we can successfully process the ACH:**

ORIGINATOR # _____

PATIENT'S Bank:_____

City: _____State: _____Zip:_____

Routing Number: _____

Account Number: Account Type: ☐ CHECKING ☐ SAVINGS

This authorization is to remain in full force and effect until Caritas Pediatrics and Wellness, PLLC.**,** has received written notification from the Patient/Parent/Guardian of its termination in such time and such manners as to afford Caritas Pediatrics and Wellness, PLLC., a reasonable opportunity to act on it.

_____

PRINT AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____

SIGNATURE

Date: _____

Notice of Privacy Practices

This notice describes how health information about You may be used and disclosed, and how You can gain access to Your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY:
Caritas Pediatrics and Wellness, PLLC (the Practice or We), is dedicated to maintaining the privacy of Your personally identifiable, protected health Information (PHI). In conducting Our business, We will create records regarding You and the treatment and services We provide to You. We strive to maintain the confidentiality of health information that identifies You. This notice explains the privacy practices that We maintain concerning your PHI.
The terms of this notice apply to all records containing Your PHI that are created or retained by the Practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will affect all of Your records that our Practice has created or maintained in the past and any records of Yours that We may create or maintain in the future. You may request a copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Caritas Pediatrics and Wellness, PLLC
300 Beardsley Lane, Bldg E, Suite 101
Austin, Texas 78746

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:
The following categories describe the different ways in which We may use and disclose Your PHI, unless you object:

1. **Treatment**. Our Practice may use Your PHI in the course of your treatment. For example, We may ask You to have laboratory tests (such as blood or urine tests), and We may use the results to help us reach a diagnosis. We might use your PHI to write a prescription for You, or We might disclose Your PHI to a pharmacy when We order a prescription for You. Our staff may use or disclose your PHI to treat You or to assist others in your treatment. Additionally, we may disclose Your PHI to others who may assist in Your care, such as other Healthcare Providers, Your spouse, Your children, or Your parents.
2. **Payment**. Our Practice may use and disclose your PHI to bill and collect payment for the services and products You may receive from Us. We do not participate or bill insurance, so We do not disclose Your information for the purpose of being reimbursed by insurance. However, We may use and disclose Your PHI to obtain payment from those who may be responsible for such costs, such as family members.
3. **Health Care Operations**. The Practice may use and disclose Your PHI to operate our business. For example, We may use and disclose Your information for our operations,

our Practice may use Your PHI to evaluate the quality of care You received from us, to develop protocols and clinical guidelines, to develop training programs, or to aid in credentialing and medical review.

4. **Appointment Reminders**. The Practice may use and disclose Your PHI to contact You and remind You of an appointment.
5. **Release of Information to Family/Friends**. The Practice may release Your PHI when necessary, to a friend or family member involved in Your care. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
6. **Disclosures Required by Law. The** Practice will use and disclose Your PHI when We are required to do so by federal, state, or local law or regulation.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which We may use or disclose Your PHI: When required by law to collect information for the purpose of:

1. **Health Oversight Activities**. The Practice may disclose Your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions and other activities necessary for the government to monitor its programs, compliance with civil rights laws, and the health care system in general.
2. **Lawsuits and Similar Proceedings**. The Practice may use and disclose Your PHI in response to a court or administrative order if You are involved in a lawsuit or similar proceeding. We also may disclose Your PHI in response to a discovery request, subpoena, or other lawful process, by another party involved in the dispute. But We shall only disclose PHI after e have made an effort to inform You of the request or to obtain an order protecting the information the party has requested.
3. **Law Enforcement**. We may release PHI if required to do so by a law enforcement official:

- regarding a crime victim in certain situations, if We are unable to obtain the person's agreement;
- concerning a death We believe has resulted from criminal conduct;
- regarding criminal conduct at Our offices;
- in response to a warrant, summons, court order, subpoena, or similar legal process;
- to identify or locate a suspect, material witness, fugitive or missing person;
- in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).

1. **Deceased Patients.** The Practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, We may also release information to funeral directors as necessary to perform their jobs.

2. **Organ and Tissue Donation**. If You are an organ donor, the Practice may release Your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation.
3. **Serious Threats to Health or Safety**. The Practice may use and disclose Your PHI when necessary, to reduce or prevent a serious threat to Your health and safety or that of another individual or the public. But We will only make such disclosures to a person or organization able to help prevent the threat.
4. **Military**. The Practice may disclose your PHI if You are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
5. **Public Health Risks.** Our practice may disclose Your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, We will only disclose this information if the patient agrees, or We are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

E. YOUR RIGHTS REGARDING YOUR PHI:
The health and billing records We maintain are the physical property of Practice. The information in it, however, belongs to You. You have a right to:

1. **Confidential Communications**. You have the right to request that our Practice communicate with You about Your health and related issues in a particular manner or at a certain location. For instance, You may ask that We contact You at home, rather than work. To request a specific type of confidential communication, You must make a written request to the Privacy Officer, identifying the requested method of contact, or location where You wish to be contacted. Our Practice will accommodate reasonable requests. You do not need to give a reason for Your request.
2. **Request Restrictions**. You have the right to request a restriction in our use or disclosure of Your PHI for treatment, payment, or health care operations. Additionally, You have the right to request that we restrict our disclosure of Your PHI to only certain individuals involved in Your care or the payment for Your care, such as family members and friends. We are not required to agree to your request; however, if We do agree, We are bound by Our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat You. To request a restriction on Our use or disclosure of

Your PHI, You must make Your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:
a. the information You wish restricted;
b. whether You are requesting to limit our Practice's use, disclosure, or both; and
c. to whom You want the limits to apply.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about You and Your care, including Your billing and medical records, but not Your psychotherapy notes. In order to inspect and/or obtain a copy of Your PHI, You must submit Your request in writing to the Privacy Officer. We may charge a fee for the costs of copying, mailing, labor and supplies associated with Your request. We may deny Your request to inspect and/or copy in certain limited circumstances; however, You may request a review of our denial. The review shall be conducted by a different licensed health care professional of our choosing.
4. **Amendment**. You may ask us to amend Your health information if You believe it is incorrect or incomplete, and You may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, Your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports Your request for amendment. Our Practice will deny Your request if You fail to submit Your request (and the reason supporting your request) in writing. Also, We may deny Your request if You ask us to amend information that is in our opinion:
   a. accurate and complete;
   b. not part of the PHI kept by or for the Practice;
   c. not part of the PHI which You would be permitted to inspect and copy; or
   d. not created by our Practice, unless the individual or entity that created it is not available to amend the information.
5. **Paper Copy of this Notice**. You may receive a paper copy of our notice of privacy practices anytime, upon request by contacting the Privacy Officer.
6. **Filing a Complaint**. If You believe Your privacy rights have been violated, You may file a complaint with our Practice. To file a complaint, contact our privacy officer at the address provided above. **Caritas Pediatrics and Wellness, PLLC**
   Attn: Privacy Officer
   All complaints should be submitted in writing, and You will not be penalized for filing a complaint. **You will not be penalized for filing a complaint.**
7. **Right to Provide an Authorization for Other Uses and Disclosures.** Our Practice will obtain Your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You have the right, at any time, to revoke Your authorization to disclose your PHI. Simply send a written notice of revocation to the Privacy Officer at the address provided above. After You revoke Your authorization, We will no longer use or disclose Your PHI for the reasons described in the authorization. Please note, We are required to retain records of Your care.

Again, if You have questions regarding this notice or our health information privacy policies, please contact the Privacy Officer listed above.

ACKNOWLEDGEMENT

I hereby acknowledge that I have received and read **Caritas Pediatrics and Wellness, PLLC's** HIPAA Privacy Policy Notice. I understand that I may request additional copies of this notice at any time.

Patient's full name:_____

Patient's Date of Birth:_____

Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the practice.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____ date _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. If I am signing this document on behalf of a minor, I represent and warrant that I am the minor's parent or legal guardian.

Informed Consent and Telehealth Services

Definition of Telehealth

For the purposes of this document, telehealth is defined as the electronic communications technologies used by the Physician and Staff at Caritas Pediatrics and Wellness, PLLC (together, the Practice), to enable them to obtain information and communicate remotely while providing Me with patient care. I understand that the same standard of care applies to medical treatment obtained through telehealth communications as applies to an in-person visit. The information obtained through telehealth communications may be used for diagnosis, treatment, follow-up and/or education and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video and data communications
- Output data from medical devices and sound and video files
- Questionnaires, email, and text messaging

The electronic systems used will incorporate network and software security protocols to protect the confidentiality of Patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Understandings

I understand that:

Telehealth involves the communication of my health information in an electronic or technology-assisted format;

All electronic medical communications carry some level of risk;

Despite reasonable security efforts, it is possible for electronic communication to be forwarded, intercepted, or changed without my knowledge;

Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided;

It is important for me to use a secure network;

Despite reasonable efforts on the part of my Physician, the transmission of medical information could be disrupted or distorted by technical failures;

I may opt-out of the telehealth visit at any time;

The Practice will maintain information exchanged during my telehealth visit as part of my Medical Record;

The Practice is not responsible for breaches of confidentiality caused an independent third party or by myself;

I must verify my identity and current location to my Physician and failure to do so may terminate the telehealth visit;

I understand that I must not use electronic communication in emergencies or time-sensitive matters;

I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.);

A medical evaluation via telehealth may limit my Physician's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my Physician's recommendations—including further diagnostic testing, such as lab testing, imaging, or an in-office visit;
There is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided;
By electronically signing or checking the box below, I am certifying that I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

Possible Benefits of Telehealth

- Easier access to medical care;
- Convenience;
- More time-efficient medical evaluation and management.

Possible Risks of Telehealth

As with any technology used in medical care, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the Provider;
- Your Physician may not be able to provide medical treatment for your particular condition remotely;
- Regulatory and other requirements may limit your Physician's ability to provide certain treatment options, including prescriptions;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures in technology equipment;
- Security protocols could fail, resulting in privacy breaches of personal medical information.

Consent for Telehealth

I, the undersigned (or parent/legal guardian) agree that my act of typing my name below will have the same legal effect as a handwritten signature. I have the choice of executing this document in either of the two ways described above. By electronically signing this document, I certify that I have read this document and understand it. I have had the opportunity to have any questions answered. I understand this document in its entirety, and I consent to participation in telehealth. I understand that I may have a hard copy of this Informed Consent upon request.

Signature of Patient/Parent/Guardian_____

Date:_____