ADAPS CONSENTS AND POLICIES

____**Consent for Medical Treatment.** I give consent to ADAPS healthcare, its staff, medical providers and other practitioners (the Practice) to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the practice for my health and well-being.

_____**Authorization of Payment of Insurance Benefits.** I authorize payment to the practice of all monies end/or benefits to which I may be entitled by government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/ all medical records about me for the purpose of payment of the service rendered to me.

_____**Signature on file (Medicare patients)**. I certify that the information given to me in applying for payments under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/ or Center for Medicare and Medicaid services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the practice for services but provided by the practice.

_____**Financial agreement.** I agree that in consideration of the services rendered to me, to pay all the amounts for which I am financially responsible, in accordance with the rates in terms of the practice. I understand that to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for all the services rendered, that I will be responsible for the payment of any balance due as determined by the respective provider of services, including deductibles, copayments, coinsurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the practice with accurate and current information regarding my insurer, HMO or other benefit plan/ third party payer which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the practice. I understand that the practice may require a consumer credit report in connection with the collection of accounts. By signing this form, I am providing the practice as well as its collection agency/ attorney with a written authorization to obtain a consumer credit report. I agree to pay all bills when presented. Should the account be referred to an attorney for collection, I shall pay all reasonable attorney fees and collection expenses. I understand that there will be a $25 charge for all returned checks.

_____**REFERRAL/ SELECTION OF PCP.** I have been notified that it is my responsibility to update my insurance to select ADAPS Healthcare/ Rosemarie Spada, FNP or any of the providers as my designated PCP effective on or before my initial appointment failure to do

so will result in my financial responsibility of services rendered

_____**Authorization for release of information.** By signing below I authorize the practice to release my health information: 1) to any requesting healthcare provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; 2) to any person or entity which may be responsible for billing/ collection of claims for medical services or products; 3) to any person or entity which is, or may be liable to the practice or me for all or part of the practices charges, including but not limited to, insurance companies, HMO's or third party payers; 4) to any government agencies or other organization responsible for oversight of the practice or a third party payer; 5) for the practice's normal healthcare operations. I authorized the practice to communicate with me through text or e-mail even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet, even though the emails may not be encrypted, and through the practice's electronic medical records.

_____**Images.** I understand that photographs or other images of me may be recorded for the practice's treatment, quality assurance purposes, safety and security. To the extent that such images identify me, I understand that they shall receive the same confidentiality protection as my other health information.

_____**Laboratory Tests:** You may request to have your laboratory tests performed at the lab of your choice. However, please be aware that not all laboratories are contracted with your insurance plan. If you choose a lab that is out-of-network or not covered by your insurance, you may be responsible for any associated fees, including the full cost of the testing.
In addition, any specialized laboratory panels requested for patients who are not established primary care patients in this practice will be processed on a fee-for-service basis. This means that these tests may not be billed through insurance, and you will be responsible for payment. We strongly recommend confirming coverage and benefits with your insurance provider prior to having labs drawn to avoid unexpected charges. If you have any questions, please contact our office for clarification before your laboratory appointment.

_____**TELEHEALTH**

1. Nature of Telehealth Services: Telehealth involves the use of secure electronic communications, video conferencing, telephone, and/or other technology to provide healthcare services when the patient and provider are not in the same physical location. Telehealth may include evaluation, diagnosis, consultation, treatment planning, prescribing (when appropriate), and patient education.

2. Potential Benefits: Telehealth may improve access to care, reduce travel time, and allow for more timely treatment and follow-up.

3. Potential Risks and Limitations - Technology failures may interrupt or limit the visit. Video or audio quality may affect the provider's ability to fully assess medical concerns. Certain conditions may require an in-person examination, laboratory testing, or referral for emergency care. Although secure platforms are used, there is a small risk of unauthorized access to protected health information.If a telehealth visit is determined to be insufficient for safe care, an in-person evaluation will be recommended.

4. Privacy and Confidentiality: Telehealth visits are conducted using HIPAA-compliant technology when available. All applicable federal and Massachusetts state confidentiality laws apply to telehealth services. Sessions will not be recorded without the patient's explicit consent. Patients are responsible for choosing a private location for their telehealth visit to help protect their own confidentiality.

5. Emergencies: Telehealth is not appropriate for medical or psychiatric emergencies. If experiencing an emergency, the patient should call 911 or go to the nearest emergency department. The provider may also direct the patient to emergency services if clinically indicated.

6. Prescribing: Prescriptions, including controlled substances when clinically appropriate and permitted by law, may be issued through telehealth in accordance with federal and Massachusetts regulations.

7. Patient Rights : Participation in telehealth is voluntary. The patient may withdraw consent at any time without affecting the right to future care or treatment. The patient has the right to ask questions about telehealth services before or during treatment.

8. Financial Responsibility: Telehealth services are billed similarly to in-person visits when allowed by payer policy. The patient is responsible for applicable copayments, deductibles, or non-covered services.

_____TELEPHONE CONSULTATION CONSENT

I understand that the practitioner / the practice may, on rare occasions, allow telephone consultations - verbal conversation only / no video. I understand that these consultations

have considerable limitations, including but not limited to no physical exam or visual assessment. I understand that my provider, during the telephone consultation, may determine that adequate care and treatment will not be possible with the limited assessment via telephone consultation. I agree to follow through with them on any required in-person office visits or video telehealth visits. I consent to receive instructions via phone/telemedicine platform and take full responsibility to follow through with specific instructions as required for my treatment. I have had the opportunity to discuss the limitations with my provider.

_____**EMAIL USE CONSENT**

The preferred method of communication is via HIPPA-compliant Patient Portal. However, the practitioner / the practice provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks: E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily copy information.

It is the policy of the practitioner / practice that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of the patient's protected personal health information. The practice cannot guarantee the security and confidentiality of e-mail or internet communication.

Patients may consent to the use of e-mail for confidential medical information after having been informed of the above risks with the following conditions: All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, insurance coordinators and, upon written authorization, other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

The practitioner / practice will endeavor to read e-mail promptly. However, the practice can provide no assurance that the e-mail will be read immediately. Therefore, e-mail must never be used in a medical emergency.

Because some medical information is so sensitive that unauthorized disclosure can be damaging, e-mail should not be used for communications concerning diagnosis or treatment of any sexually transmittable or communicable diseases such as syphilis,

gonorrhea, and the like; behavioral health, mental health; or alcohol and drug abuse.

The practitioner / practice cannot guarantee that electronic communications will be private. The practitioner / practice is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time, whether it be by e-mail or written communication to the practitioner / practice. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail

_____**TEXT MESSAGING CONSENT**

The practitioner / practice may need to use my name, address, phone number, and my clinical records to contact me with appointment reminders/text message, information about treatment alternatives or other health related information that may be of interest to me. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone.

Message and data rates may apply and message frequency may vary. You can contact the practice at any point to request that your mobile number not be used for messaging. You can text HELP for support or more information and STOP to unsubscribe from text messages at any time. If you unsubscribe, you will no longer get appointment reminder messages. Your phone number will not be shared with third parties for marketing or promotional purposes.

By signing this form, I am giving the practice the authorization to contact me with these reminders and information and to leave a message on my answering machine or with individuals at my home or place of employment.

_____**Acknowledgement of notice of privacy practices.** I have access to a copy of the practices notice of privacy practices, and have had the opportunity to receive assistance and the understanding and exercising these rights. Our practice uses a HIPAA compliant and secure AI/virtual remote scribe which allows us to complete our medical charts more quickly and efficiently and focus more on you. If you have any questions about our remote scribe, please let us know.

ADAPS CONSENTS AND POLICIES

Financial Policy:
Cancellation/ No Show Policy:

Thank you for trusting your medical care to ADAPS Healthcare. When you schedule an appointment, we set aside enough time to provide you with the highest quality care. We understand there may be times when an unforeseen emergency occurs, and you might not be able to keep your scheduled appointment. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation/ no show policy below:

-**Any primary care patient** who fails to show or cancel/ reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a no show in charged a $50 fee

-**Any Fee for service appointments** A $50 non-refundable booking fee is required to secure your appointment and will be credited toward your treatment. Cancellations or no-shows will result in forfeiture of this fee.

-**Any Injection only appointments** A $25 non-refundable booking fee is required to secure your appointment and will be credited toward your treatment. Cancellations or no-shows will result in forfeiture of this fee.

Cancelation and No Show Fees Responsibility

-The fee is charged to the patient, not to the insurance company, and will be automatically collected on the day of the no show, utilizing the credit card on file (see below).
-As a courtesy, we may send out reminder emails, texts and occasional calls. If you do not receive a reminder, call or message, the above policy will still remain in effect as it is your responsibility to remember your appointment times.

PHONE CALLS - Phone calls requiring 10 minutes or more of the provider's time will be charged as a minimum visit ($40/15 minutes).

COPIES - The cost for copies of lab work, chart notes, imaging, and invoices will be 50 cents per page, EXCEPT if requested at the time of the visit. Lab work, chart notes, imaging, and invoices
pertinent to the visit will be provided free of charge on the day of the visit. Most documents will also be available for you on the patient portal.

SPECIAL LETTERS, FORMS, and DOCUMENTS - Completing special insurance forms, workplace documentation, writing letters of medical necessity, etc. require significant provider time and will be charged an administrative fee of $25 per document/letter. Fees must be paid in advance. Some documentation may require extensive time / complexity and may justify a higher fee. If so, this fee will be disclosed to you prior to preparing the documents.

SUPPLEMENT DISCLAIMER

Many supplements, vitamins, medical grade foods, nutritional powders, botanicals, and homeopathic remedies have not been evaluated by the US Food & Drug Administration (FDA) and these products are not intended to diagnose, treat, cure, or prevent any disease.

NO REFUNDS, CREDITS, OR EXCHANGES are allowed on any supplement(s), herbs, homeopathic remedy/remedies, vitamins, and nutritional supplements. Once these items have been purchased or left the office, they cannot be brought back under any circumstance.

All services and supplementation must be PAID IN FULL at the time of service. A remaining balance is not allowed.

- Supplements will not be held, picked up or shipped without prior payment.
- Special orders need to be paid for at the time of order. Once paid for, there will be no credits, refunds, exchanges, or modifications allowed.

Supplements may be bought directly from our trusted online dispensary (FullScript) or you can choose to purchase them at a dispensary of your choice. The cost of supplements is not included in the visit fee.

Please inform the practitioner if you are vegetarian and require vegetarian supplementation. Remember, there are NO refunds, exchanges or credits given. All sales

are FINAL.

Credit Card Authorization:
ADAPS healthcare requires a credit card on file. This is an explanation of when the credit card will be used. Your signature below indicates that you authorized the usage as detailed below.

Your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit, you will be responsible for certain parts of the bill such as deductible, co-insurance and copay. In addition, if you do not provide us with the correct information to process your claim, such as your insurance card, and the claim is denied, you will be responsible for these charges as well. According to your insurance plan, we are required to collect your copays, deductibles, and/or coinsurance. In providing the credit card information below you authorize payment for services rendered, including copays, co-insurance, deductibles, and or uncovered services.

Once your insurance settles the claim and notifies us of your patient responsibility, balances under $200 will be charged AUTOMATICALLY. “NO SHOW” Fees will also be charged automatically.

For primary care patient balances exceeding $200, you will be notified by us prior to your credit card being charged.

A receipt for the amount charged will be automatically emailed, texted, or mailed to your home.

The security of your personal information is of the utmost importance to us. As such we use encrypted software to store your credit card information. To store your information into encryption you will need to swipe your card. As a result of this swipe you may see a charge for 0.1 cent on your account. In the event that your card is charged, we will place a one cent credit on your account which can be applied to future balance. Alternatively, you can ask us for a cash refund of the one cent presenting us a copy of the charge.

By signing below you acknowledge that you have read all the consents and policies including the no show policy/credit card policy above, you understand its terms and you accept full responsibility for all services rendered.

ADAPS CONSENTS AND POLICIES

I have carefully read and fully understand the consent and policies and have had all my questions answered.