# CONSENT TO TREAT

I, _____ _____. hereby consent to the administration and performance
Patient Name Date of Birth

of any and all diagnostic procedures and treatments, which in the judgment of my physician may be considered necessary or advisable.

# RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I consent and understand that REENA R PATEL MD INC will share my Protected Health Information (PHI) according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. REENA R PATEL MD INC may disclose all or any part of my medical record and/or financial ledger, to any person orcorporation (1) which is or may be liable or under contact to REENA R PATEL MD INC for reimbursement for services rendered, and (2) any healthcare provider for continued patient care. A copy of this authorization may be used in place of the original.

# HIPAA ACKNOWLEDGMENT OF PATIENT PRIVACY

REENA R PATEL MD INC is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of your treatment, we may be required to share information with other medical providers for the benefit of your care. This is all within the regulations set by the Federal and State laws regarding PHI. Your information is only released with your consent and can be revoked at any time by you as provided by law. If you have any questions regarding this consent, please feel free to ask our staff members. We can provide you with a copy of our "Notice of Privacy Practices" at your request, which states how we may use and/or disclose your health information.

By signing this form, I acknowledge that I have reviewed all policies: Notice of Privacy Practices, Office Policies and the Office Membership Agreement. Copies of these policies can be requested as well as are available on the website: www.ReenaMD.com.

# CANCELLATION OR RESCHEDULING NOTICE

Our practice values our patients and specifically reserves an appointment time for you to address your questions and concerns. Because of this, we ask that you notify our office 24-hours in advance to reschedule or cancel your appointment.

# EMAIL/TELEMEDICINE (VIDEO/PHONE/TEXT)

**EMAIL:** To stay as Green as possible, Dr. Patel will be primarily be sending information that may contain protected, privileged, and highly confidential medical, Personal and Health Information (PHI), which may include but not limited to labs, imaging, handouts, and/or legal information via email. **While we do our best to use a HIPAA compliant email, please understand that there is no guarantee and information communicated may not be entirely secure.**

At any time, you may notify Dr. Patel if you do not want or if there is certain information that you would prefer not to be sent via email/text.
For a more secure form of communication, we recommend you primarily using your Patient Fusion Portal.Please let us know if you need any assistance in accessing your portal.

**TELEMEDICINE (VIDEO/PHONE/TEXT)**

1. **PURPOSE:** By reviewing and signing below, you are acknowledging and consenting to the use of telemedicine consultations via email/video/phone/text with a physician. The purpose of the consultation is to assist in the Patient's medical care, diagnosis, management and treatment.

2. **NATURE OF TELEMEDICINE CONSULTATION:** Telemedicine involves the use of audio, video, or other electronic communications to interact with you, consult with the healthcare provider and/or review the Patient's medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals though the use of interactive video, audio and telecommunications technology.
Additionally, a physical examination of you may be directed to take place and video, audio, and/or photo recordings may be taken or reviewed.

3. **RISKS, BENEFITS, AND ALTERNATIVES:** The benefits of Telemedicine include having possibly more accessibility to the healthcare provider as well as access additional medical information and education without having to travel. A potential risk of telemedicine is that because of specific medical conditions, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine consultation. Additionally, in rare circumstances, security protocols could fail causing a breach in patient privacy. The alternative to telemedicine consultation is a face-to-face visit with the healthcare provider.

4. **MEDICAL INFORMATION AND RECORDS:** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation(s) to any third-party shall not occur without your consent.

5. **CONFIDENTIALITY**: All existing confidentially protections under federal and California law apply to information used or discussed during your telemedicine consultation.

6. **RIGHTS:** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any Practice benefits to which you would otherwise be entitled.

## PLEASE REFER TO "EXHIBIT A" ATTACHED HERETO

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

## MEDICARE PATIENTS ONLY

## PLEASE REFER TO "EXHIBIT B" ATTACHED HERETO

## PAYMENT POLICY

## AFFIRMATION

- **The patient demographics and Medical History entered are true to the best of my knowledge.**
- **I have reviewed and agree to the release of information and assignment of benefits.**
- **I have reviewed and agree to the terms of the Office Polices & HIPAA-Notice of Privacy Policies.**
- **I have reviewed and agree to the terms of the Email/Telemedicine (video/phone/text).**
- **I have reviewed and *signed* the Physician-Patient Arbitration Agreement "Exhibit A."**
- ***For Medicare only,* I have reviewed and agree to the terms of the Payment Policy "Exhibit B."**

**Your signature below signifies your understanding and willingness to comply with the all above policies.**

| | |
|---|---|
| Patient Name | Date |
| Patient's Signature | |
| Name of Legally Authorized Representative | Date |
| Signature of Legally Authorized Representative | Relationship to Patient |

# EXHIBIT A

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5 : **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: Reena R. Patel MD 12/27/21
Physician's or Duly (Date)
Authorized Representative Signature

By: REENA R PATE MD INC
Print or Stamp Name of Physician,
Medical Group or Association Name

By:
Signature of Translator (if applicable) (Date)

Print Name of Translator

By:
Patient's Signature (Date)

Patient Name

By:
Patient's Representative's Signature (if applicable) (Date)

Print Name and Relationship to Patient

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.

# EXHIBIT B

## APPLICABLE TO MEDICARE PATIENTS ONLY

## PAYMENT POLICY

REENA R PATEL MD INC is a Medicare provider. Patient authorizes the office of REENA R PATEL MD INC to bill Medicare and assign all medical benefits to be paid directly to REENA R PATEL MD INC for services and supplies rendered by REENA R PATEL MD INC and/or staff. Patient hereby authorize REENA R PATEL MD INC to release all information necessary to process claims and secure payment of benefits. Patient will be financially responsible for all co-payments, co-insurance and deductible amounts under Patient's Medicare.

Patient is also financially responsible for all treatments or procedures, including understanding Patient's plan specific rules regarding covered services, approved providers, referrals, authorizations and out-of-pocket payments. In addition, the Patient will solely be financially responsible for payment of any health care services not covered by Patient's primary and/or secondary insurance, including all charges remaining after insurance reimbursement. Under no circumstances shall the REENA R PATEL MD INC charge Patient personally for any healthcare services covered by Medicare.

Patient's insurance will be billed immediately upon service and credit card charged within ninety (90) days of such billing for (1) any fees not collected at time of healthcare services; (2) co-insurance and deductibles for the REENA R PATEL MD INC'S healthcare services provided; (3) charges for healthcare services provided not covered by Patient's Medicare.

All unpaid balances over 90-days overdue will turned over to a collection agency. You will then be responsible for all collection costs, including but not limited to any court, attorney, collection fees, and interest fees.

We accept most major credit or debit cards, with the exception of American Express, cash, checks and ACH for payments.

**Please note: A 2% service fee will also be charged for any Credit Card or Debit Card transactions.**