PONTE VEDRA CONCIERGE MEDICINE

COMMUNICATION AUTHORIZATION

My signature and choices noted below verify my acknowledgement of the following:

- I fully understand both voice and electronic communication between myself and the Clinic and its associated entities and staff. I understand the risks associated with voice, online, email, and text message communications between my provider/provider's staff and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the Patient Portal log in screen, as well as any other instructions that my physician may impose to communicate with patients via online and alternate forms of communications.

- Commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I further agree to be held accountable and to comply with the patient responsibilities as outlined in the "Patient Communication Policy."

- In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via both secure-encrypted and non-secure email services.

- I understand that I may revoke or alter my consent to communicate electronically at any time by notifying the practice in writing at the address below, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent.

- I have been given the opportunity to discuss electronic communication with a representative of the Clinic and have had all my questions answered. I agree and release my provider and practice from any and all liability that may occur due to accidental misuse of electronic communication over both secure and non-secure networks.

I acknowledge the need for and grant permission to the Clinic (and affiliates) to communicate lab results, health information, account/billing information, and appointment confirmations to me using the following means:

Secure Patient Portal and Athena Health Application that is operated through Athena Electronic Medical Record system. The email address provided will be used for the sole purpose of establishing an electronic patient portal account.

Secure/Encrypted Email for messages and documents that may contain personal health information. Traditional Email for messages that do not contain personal health information.

Email: (Please Print)	

Text and/or Voice Messaging for appointment notifications and confirmations.

Cell Number:	Carrier:

____________________________________ ________________

Printed Name Date

____

Signature

CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my diagnosis.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient’s Full Name

Date of Birth

Patient’s signature

Date

Parent, Guardian, or legal Representative Signature

Witness of Signature

PONTE VEDRA CONCIERGE MEDICINE

FINANCIAL AGREEMENT

Patient's Full Name:	
Patient's Date of Birth:	

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by email and/or text for appointment reminders, waiting lists, missed appointments and marketing of services provided by Ponte Vedra Concierge Medicine (the "Practice").

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay applicable membership fee to be paid monthly.

Payment may be made to the Practice in the form of Cash, Check, Debit and Credit Cards.
I understand additional charges ($40) are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account. I may also be charged if I do not cancel my scheduled appointment, or for not paying my membership responsibility within ten (10) days.

COLLECITON AND REFUND POLICY AND DISCHARGE FROM PONTE VEDRA CONCIERGE MEDICINE

Patients who do not pay their membership dues within 10 days of their monthly membership fees will have their account placed on hold and discharged from the practice with a 30 days' notice to seek care.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Signature*

Date*

Parent, Guardian or Legal Representative*

PONTE VEDRA CONCIERGE MEDICINE

KNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER OR OTHER THIRD PARTY

I authorize the Practice to release my medical and /or billing information to the following individual(s):

Name (1)

Relationship to Patient:

Name (2)

Relationship to Patient:

Name (3)

Relationship to Patient

I hereby authorize the disclosure of my individually identifiable health information to the individual(s) listed above. I understand that this authorization is voluntary. I further understand that if the party authorized to receive the information is not a health plan or health care provider; the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release the Practice from all liability arising from this disclosure of my health information. I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmissible diseases (including tests results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.

PONTE VEDRA CONCIERGE MEDICINE

KNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Furthermore, I hereby give consent for disclosure of medical information to any third party who I allow to be present in the room during my visit/treatment.

Patient Full Name

Date of Birth

Patient Signature

Date

Parent, Guardian, or Legal Representative Signature

Witness of Signature

Medical Intake Form

Past Medical History

Have you ever had any of the following? (Check boxes that apply):

- Allergies
- Anxiety
- Arthritis(Rheumatoid/ Osteo)
- Artificial heart valve or joints ___________
- Back problems
- Bleeding abnormality
- Blood disease
- Cancer (type) _________________
- Cataracts
- Chronic Diarrhea (Crohns, Ulcerative Colitis/Irritable Bowel/Other)
- Circulatory Problems
- COPD
- Dementia
- Diabetes
- Depression
- Epilepsy
- Esophogeal Reflux Disease
- Headaches (migraine/tension)
- Heart murmur
- Heart disease
- Hemophilia
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Liver disease
- Pacemaker
- Prostate Enlargement
- Stroke
- Sinus Problems
- Thyroid Disease(Hypo/Hyper/ Nodule)
- Ulcers
- Other:_____________ _________________ _________________ _________________ _________________ _________________

Medications

☐ None

List:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Allergies

☐ None ☐ ____

Surgery History

☐ None ☐ ____

Family History

☐ None

Father: ______________________________

Mother: _____________________________

Siblings:_____________________________

Other:_______________________________

Social History

Tobacco: (Check boxes that apply):

- Never
- Former smoker
  Year quit: ______
  Years smoking: ______
  Packs per day: _______
- Currently smoking
  Packs per day: _______
  Years smoking: ______
- Smokeless tobacco
- Vaping

Alcohol (circle): None Occasional 2-5 days per week >5 days per week

If you drink, how many drinks per day? _______

Any illicit drug use: ☐ None ☐ ___________________________________

Marital status (circle):

Married Single Divorced Widow Domestic partner

Sexual orientation (circle): Heterosexual Homosexual Bisexual

Advanced Directives: Yes No

Specialists

☐ None

List:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Patient Name: _______________________________ DOB: __________________

Signature:___________________________________ Date: __________________

PONTE VEDRA CONCIERGE MEDICINE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Ponte Vedra Concierge Medicine, we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule effective March 26, 2013. It applies to all PHI as defined by federal regulations.

Ponte Vedra Concierge Medicine participates in an Organized Health Care Arrangement ("OHCA") with local hospitals. An OHCA is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more Covered Entities who participate in joint activities to share the PHI about their patients in order to manage and benefit their joint operations. RMS will share PHI with participants in the OHCA for treatment, payment and health care operations of the OHCA.

Understanding Your Health Record/Information

Each time you visit Ponte Vedra Concierge Medicine, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Ponte Vedra Concierge Medicine, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. You have the right to inspect and/or request a paper copy of your medical record. If the Ponte Vedra Concierge Medicine office where you receive services maintains an electronic medical record ("EMR"), you have the right to access your health record in a machine-readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. Ponte Vedra Concierge Medicine may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. Ponte Vedra Concierge Medicine is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for Ponte Vedra Concierge Medicine; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by Ponte Vedra Concierge Medicine, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If the Ponte Vedra Concierge Medicine office where you receive services maintains your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but Ponte Vedra Concierge Medicine may charge you for additional lists within the same 12-month period. Ponte Vedra Concierge Medicine will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases Ponte Vedra Concierge Medicine is not required to agree to these additional restrictions, but if Ponte Vedra Concierge Medicine does, Ponte Vedra Concierge Medicine will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). Ponte Vedra Concierge Medicine must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine-readable electronic format.

Our Responsibilities

Ponte Vedra Concierge Medicine is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the Ponte Vedra Concierge Medicine Privacy Officer at:

Ponte Vedra Concierge Medicine
Attn: Privacy Officer
100 Executive Way
Ponte Vedra Beach, FL 32082-2781
Telephone: (904)820-2074

If you believe your privacy rights have been violated, you can file a written complaint with Ponte Vedra Concierge Medicine Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, Ponte Vedra Concierge Medicine operates an EMR. This is an electronic system that keeps health information about you. Ponte Vedra Concierge Medicine may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. Ponte Vedra Concierge Medicine may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

Ponte Vedra Concierge Medicine may use a prescription hub which provides electronic access to your medication history. This will assist Ponte Vedra Concierge Medicine health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by encrypted e-mail, in reference to any items that assist Ponte Vedra Concierge Medicine in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist Ponte Vedra Concierge Medicine in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain

specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. Ponte Vedra Concierge Medicine may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at RMS, to a business associate or a foundation related to RMS so that they may contact you to raise money for RMS. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: Ponte Vedra Concierge Medicine may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability..

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

PONTE VEDRA
CONCIERGE MEDICINE

Registration Form

Last Name: ______________________________

First Name: ______________________________

Sex: Male/Female

DOB: ______________________________

Address: ______________________________
____
____

Home Phone: ____________________ Mobile Phone: ____________________
Email: ________________________________
Consent to call: YES/NO
Consent to text: YES/NO

Emergency Contact: ______________________Relationship: __________
Home phone: ______________________
Mobile Phone: ______________________

Guarantor: ☐ Self
Last Name: ______________________________
First Name: ______________________________
DOB: ______________________________
Address: ______________________________
____
____
Home Phone: ______________________________
Mobile Phone: ______________________________

Insurance carrier (for referrals only): ______________________________

PONTE VEDRA CONCIERGE MEDICINE

TELEMEDICINE CONSENT FORM

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving information may be used for diagnosis, therapy, follow-up and or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols and 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.

1. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation

    - Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals using interactive video, audio, email, and telecommunication technology.

    - Video, audio and/ or photo recordings may be taken of you during the procedure(s) or service(s)

2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this or information for this telemedicine interaction to researchers or other entitles shall not occur without your consent.

3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.

4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

5. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Florida, and Florida law shall apply to all disputes.

6. RISKS, CONSQUENCES & BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have

been answered, and you understand the written information provided above.

- I agree to participate in a telemedicine consultation for the procedure(s) described above.
- I refuse to participate in a telemedicine consultation for the procedure(s) described above.

I have read and understand the information in this agreement. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I agree and give my consent to the use of telemedicine for medical care.

Patient Print

Patient Signature

Patient Date of Birth

Date

Parent, Guardian, or Legal Representative Signature

Witness of Signature