CONSENTS & POLICIES

FINANCIAL POLICIES

FEES AND PAYMENTS

As the patient, it is in your best interest to know and understand your insurance plan benefits. It is important that you know your benefits prior to visiting. Regardless of your individual insurance coverage or type, as the person seeking medical treatment, **you are ultimately responsible for all charges**.

All bills will be sent via email. Please watch your email for notifications that there is an outstanding balance on your account.

Please know that we are here to help you if you have any questions.

All outstanding balances must be paid in full prior to the next office visit.

MISSED APPOINTMENT FEE

We required 48-hour notice if you are unable to keep your appointment. If you miss an appointment, fail to give sufficient notice, or arrive more than 10 minutes late, **you will be charged $50 for that missed appointment**. This payment is expected before any further treatment is provided.

PAST DUE ACCOUNTS

If your account becomes past due, we will take necessary steps to collect this debt. At the time of your initial office visit, a copy of your credit card will be taken. If your account becomes past due over 7 days, **that credit card will be charged**. If the credit card declines or there are any other problems, **your account will be referred to our collection agency**. You will be charged for this service in addition to your current account balance. If payment is not received, your credit report will be blemished. If we have to refer the collection of the balance to a lawyer, you agree to pay all of the lawyer's fees which we incur, plus all court costs.

CREDIT CARD AUTHORIZATION

I authorize the practice to maintain my credit card number in the electronic health record and to use it to process payment for services rendered or supplements or other items purchased by me.

I authorize the practice to process the credit card on file for any balance due on my account past 7 days and for any payments authorized by me.

I understand that a receipt superbill and receipt showing what was paid for will be sent to me within 30 days of each visit. I know that I am responsible for letting the clinic know if anything has changed concerning my credit card information.

LABORATORY TESTS

I understand that Samira Shokati, FNP, DNP, ARNP (henceforth referred to as "the practitioner") / the practice may recommend blood, saliva, stool, urine, hair, or skin testing within their scope of practice. In addition to conventional testing, specific tests may be ordered through specialized laboratories to assess structural and/or functional deficiencies, and may not always be diagnostic, but can provide critical information to help improve my health outcomes. I agree with the use of such tests and will always have the opportunity to discuss their applicability and limitations with my provider, prior to sample collection. I agree to pay the laboratory any fees due for sample collection and processing.

TELEHEALTH CONSENT

I consent to voluntarily engaging in a telemedicine consultation with the practice. I understand that the video conferencing technology will not be the same as a direct patient/health care provider visit:

Telehealth consultation has potential benefits, including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home. It also has potential risks including interruptions, unauthorized access, and technical difficulties.

I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

If there is another individual present during the telehealth consultation, I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through the practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.

Telemedicine services offered through the practice are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.

To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

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.

AI SCRIBE CONSENT

To provide you with the best care and attention, we use a service called Freed that transcribes conversations and helps with notes. Your information is private and we review the content for accuracy. You can withdraw this consent at any time.

WELLNESS INJECTIONS CONSENT

During your visits, the practitioner may recommend wellness injections. These include, but are not limited to: B12 Shot, Biotin Shot, NAD+ Shot, Skinny Shot, Amino Boost, Vitamin D3 Shot, and Tri Immune Boost.

If you elect to receive one or more of these injections, note that common side effects include, but are not limited to: mild diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache, and joint pain.

If any of these side effects become severe or troublesome, you need to contact the practitioner immediately.

You understand that, although rare, wellness injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking wellness injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of wellness injections, and such side effects should be reported to the practitioner to be evaluated for seriousness. Uncommon and dangerous side effects include: headache, nausea, diarrhea, bloating, constipation, indigestion or heartburn, abnormal bleeding, gastrointestinal hyperactivity, chest pain, flushed face, chills, fever, upset stomach, kidney stones, fingernail weakening, hair loss, rapid heartbeat, heart palpitations, restlessness, muscle cramps and weakness, and dizziness.

You understand the possibility of having an allergic reaction to any of the ingredients found within the wellness injection is quite plausible and that you should communicate with the practitioner if I have any known allergic reactions to foods, dyes, preservatives, or any other substances. If you experience any of these following signs of allergic reactions you should immediately consult the practitioner and discontinue further use of the product. Signs of allergic reactions include, but are not limited to: itching of skin, hives, rashes, wheezing, difficulty breathing, and swelling of mouth or throat.

When medications are taken in conjunction with the wellness injection, drug interactions could occur. These interactions can either increase your risk of bleeding or block the absorption of the ingredients into the body. These medications at the time of your injection should either be discontinued or be consulted with the practitioner. Some of the medications that may cause drug interactions include, but are not limited to: Heparin (Fragmin, Lovenox, Innohep, etc), Antithrombin (A Tryn, Thrombate III), Argatroban, Aspirin, Ibuprofen, Dipyridamole (Persantine), Bivalirudin (Angiomax), Clopidogrel (Plavix), Warfarin (Coumadin, Jantoven), and Nonsteroidal anti-inflammatory drugs (Ibuprofen, etc).

Before starting the welnesss injections you will make sure to tell the practitioner if you are pregnant, lactating, or have any of the following conditions: Leber’s Disease, kidney disease, history of kidney stones, liver disease, hormonal disease, cardiovascular disease, history of ulcers, history of gastrointestinal problems, bipolar disorder (manic depression), attention deficit hyperactivity disorder (ADHD), muscular dystrophy, epileptic seizures, hypoglycemia, schizophrenia, benign prostatic hypertrophy (BPH), acetaminophen poisoning, hypertension (high blood pressure), history of seizures, under-active thyroid (hypothyroidism), osteoporosis, receiving treatment or taking any medication that might “thin” the blood, receiving treatment or taking medication that has an effect on bone marrow, an infection, iron deficiency, folic acid deficiency, dependent on intravenous nutrition (TPN) or liquid nutrition products for food, diabetes, mellitus, or high blood sugar levels, or an unusual or allergic reaction to medicines, foods, dyes, or preservatives.

You understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non prescription medications may result in side effects when they interact with the wellness injection.

Treatments will be determined by the practitioner.

You hereby release the practitioner and Woodinville Family Medicine & Dermatology from liability associated with this procedure today or at any future date.

APPOINTMENT REMINDERS 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.

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.

RELEASE OF INFORMATION

I may restrict the individuals or organizations to which your health care information is released or I may revoke your authorization at any time: however, this revocation must be in writing and mailed to the office address. The practice will not be able to honor my revocation request if they have already released my health information before the request to revoke authorization. In addition, if I was required to give my authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that the practice may use or disclose based on the authorization I am giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. I have the right to refuse to give us this authorization. If I do not give authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care.

I may inspect or copy the information that is used to contact me to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective on the date of signature. This authorization will expire seven years after the date on which I last receive services from the practice.

I authorize you to use or disclose my health information in the manner described above. I acknowledge that I have received a copy of this authorization.

PRIVACY POLICY / HIPPA COMPLIANCE

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you with how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact the practice at 13110 NE 177th Pl, Unit B102, Woodinville, WA 98072, (425) 900-2872 or info@samirashokati.com at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

- Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care. For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.
- Payment: Your protected health information may also be used to facilitate payment or reimbursement to you from an insurance company or another third party. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

- Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you by telephone, email, or text to remind you of your appointments.
- If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.
- We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.
- We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.
- Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.
- Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.
- Research: We will not use or disclose your health information for research purposes unless you give us authorization to do so.
- Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.
- Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.
- Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.
- Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.
- Workman’s compensation: We may disclose your protected health information to workman’s comp or similar programs.
- Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.
- Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected

health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

- Amendment: If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You will need to submit a written request as to why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason why it should be amended. If we deny your request, we will provide you with a written explanation. We may deny your request if we believe the protected health information is accurate and complete.
- Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" from the individual listed at the bottom of this policy. After your request has been approved, we will provide you with the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. We reserve the right to charge a reasonable fee for this process.
- Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.
- Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.
- Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.
- Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:
Aaron Dahlen
Woodinville Family Medicine & Dermatology
13110 NE 177th Pl
Woodinville, WA 98072
(425) 900-2872

PATIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, and respect. As one of our valued clients, you are entitled to the following:

You have the right:

- To be treated with respect and dignity.
- To know the name and professional status of the person(s) serving you.
- To privacy and confidentiality.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side-effects of all forms of treatment.
- To participate in choosing the form of treatment best suited to you.
- To receive education and counseling about treatment.

- To review your medical record with your clinician.
- To amend your records.
- To receive any information about potential services or related services.

You have the responsibility:

- To seek medical attention promptly, and to provide useful feedback.
- To be honest about your medical and social history.
- To be honest about your lifestyle risks and exposures.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To respect clinic policies.
- To show up for appointments or cancel 48 hours in advance.

We respectfully ask that you do not bring guns, knives, or other weapons into the clinic.

By signing this form, I certify:

I have read this form or had this form explained/read to me.

I have read or had this Financial Policy explained/read to me. I understand its contents and agree with and accept the terms and requirements.

I have read or had this AI Scribe Consent explained/read to me. I understand its contents and agree with and accept the terms and requirements.

I have read or had this Wellness Injections Consent explained/read to me. I understand its contents and agree with and accept the terms and requirements.

I have read or had this Privacy Policy / HIPPA Compliance Policy explained/read to me. I understand its contents and agree with and accept the terms and requirements.

I have read or had the Patient's Rights and Responsibilities explained/read to me. I understand its contents and agree with and accept the terms and requirements.

I have had the opportunity to ask questions and have had them answered to my satisfaction.

Name(s) of Person(s) who may receive protected health information on your behalf:

_____

Name of Parent / Guardian, if signing for patient:

_____

Signature: _____ Date: _____