In Network Deductible

Plese read, sign and accept the policy below

VIDA Dermatology and Aesthetics

NOTIFICATION OF IN-NETWORK DEDUCTIBLE

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your nurse practitioner may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. As per the rules of your insurance carrier, you will be responsible for covering any deductible payment.

The nurse practitioner of Vida Dermatology and Aesthetics follows strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are punch biopsy, punch excision, and excision.

Name _____

Sign _____

Date ____/____/_____

Notice of Privacy Practices

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

If you have any questions about this notice, please contact our Privacy Officer at: 750 Broad Street, Suite 104, Shrewsbury, NJ 07702. (732) 307-3432

WHO WILL FOLLOW THIS NOTICE

This notice describes how we may use and disclose your protected health information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to give you this notice stating our legal duties and privacy practices with respect to your protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our notice at any time. A revised notice will be effective for all protected health information that we maintain. A revised Notice of Privacy Practices will be made available to you either by contacting our office and requesting that one be sent to you in the mail or asking for one at the time of your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use and disclose your protected health information to provide, coordinate, or manage your medical treatment and related services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering imaging. Other health care providers may be part of your medical care outside of this office and may require information about you that we may have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide

what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders We may use your health information to generate an appointment reminder that will be sent to you by telephone, email, text message, or other means and informs you of the date, time and location of your next appointment.

Treatment Alternatives and Health-Related Products and Services
We may tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may use your name and address to send you a brochure about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

SPECIAL SITUATIONS

We may use or disclose health information about you **without your permission** for the following purposes, subject to all applicable legal requirements and limitations:

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Public Health Activities We may disclose health information about you for public health activities, including disclosures:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products of services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; -to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

To Avert a Serious Threat to Health or Safety Subject to applicable law, we may use and disclose health information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person or, if necessary, for law enforcement authorities to identify or apprehend an individual.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws or other legal or regulator requirements.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena or other legal process.

Specialized Governmental Functions In certain circumstances we may be required to disclose information about you to authorized governmental agencies for national security activities or for protective services for the President or other authorized persons.

Workers' Compensation We may release health information about you as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Law Enforcement We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Military Veterans If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Disaster Recovery Efforts When permitted by law, we may coordinate our uses and disclosures of protected health information with public entities authorized by law or by charter to assist in disaster relief efforts.

Incidental Disclosures Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are byproducts of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may release information to a Funeral Director, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Organ and Tissue Donations If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Research We may use and disclose health information about you for research projects that are subject to a special approval process and the requirements of applicable law.

Family and Friends We may disclose to your family members or friends health information about you which is directly relevant to their involvement in your care or payment for your care, 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. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we

will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up your health information or records, for example, X-rays. Additionally, we may use or disclose your protected health information to notify or assist in the notification of a family member or friend responsible for your care or your Location, general condition or death.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization.
Most disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute the sale of your health information require your prior written authorization. We may, however, provide you with marketing materials in a face to face encounter without your authorization or communicate with you about treatment alternatives or other health related products and services that may be beneficial to you in relation to your treatment. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, except to the extent that we have already taken action in reliance on your authorization.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization) from you. In order to disclose these types of records for purposes of treatment, payment and health care operations, we will have a special written authorization that complies with the law governing HIV or substance abuse records, when required by applicable law.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy You have the right to inspect and/or obtain a copy of your health information, such as medical and billing records for as long as we maintain that information. This includes the right to receive in an electronic format a copy of your health information that is maintained as part of an electronic health record and to have the electronic record transmitted directly to an entity or person designated by you. You must submit a written request to your physician in order to inspect and/or obtain a copy of your health information. If you request a copy of the information, we may charge a fee for the costs of copying as approved by state law. We will try our best to provide your health information to you in the form or format requested by you if such form or format is available. If it is not, the information will be provided in a readable hard copy form or such other agreed upon form. We may deny your request to inspect and/or copy in certain limited circumstances. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

Right to Amend If you believe health information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We may deny your requestfor an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: a) We did not create, unless the person or entity that created the information is no longer available to

make the amendment. b) Is not part of the health information that we keep. c) You would not be permitted to inspect and copy the record at issue. d) Is accurate and complete.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment and health care operations.

We are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You may also request that we restrict disclosure to your health plan of any health information related to an item or service for which you or someone on your behalf, other than the health plan, paid us in full. If you make such a request we will not disclose such health information to your health plan as part of our payment or health care operations unless we are otherwise required to do so under the law. To request restrictions, you may complete and submit to the Privacy Officer the Request For Restriction On Use/Disclosure Of Medical Information and/or Confidential Communication Form.

Right to be Notified in the Event of a Breach We are required to notify you in the event of a breach of your unsecured health information as soon as possible but no later than sixty (60) days after we discover the breach.
Unsecured health information is information that is not deemed unreadable, unusable, or indecipherable using technology, such as encryption, or other means specifically approved by the Secretary of the U.S. Department of Health and Human Services. Any required notice will include a description of the breach, the unsecured health information involved, steps you might have to protect yourself, a Summary of our investigation, and how to contact us for more information.

Right to Request Confidential Communications You have the right to reasonably request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To make such a request, you may complete and submit the Request For Restriction On Use/ Disclosure Of Medical Information And/Or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

NOTIFICATION OF IN-NETWORK SURGICAL BENEFITS

As a medical specialty practice the nurse practitioner may perform diagnostic, and in some cases, minor surgical procedures in the office when necessary to provide you with a thorough evaluation of your complaint. Some insurers now offer health benefit plans that apply the cost of these procedures (in-network surgical deductibles). Even though a procedure is diagnostic by definition, some insurers may consider it "surgical" because of its coding classification by the American Medical Association.

Vida Dermatology and Aesthetics will likely not know whether a patient has a policy involving an in-network surgical deductible until the claim is processed. If you do not know whether your health plan includes this type of in-network deductible, we suggest you contact your insurer. We will continue to submit all claims for covered services we render to your insurance company for payment, but you are responsible for any deductible, coinsurance or co-payment amounts determined by your insurer to be due owing to Vida Dermatology and Aesthetics.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE AND AGREE TO ITS TERMS.

Name _____

Sign _____

Date ____/____/_____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

By signing below, I allow Vida Dermatology and Aesthetics to obtain medication history via electronic means directly from my insurance and/or pharmacy.

PATIENT CODE OF CONDUCT

Vida Dermatology and Aesthetics is committed to providing high quality care and service to our patients and their families and maintaining a sate, respectful, and dignified environment for our patients, visitors, and staff. Communicating our Patient Responsibilities and Code of Conduct guidelines helps us meet these goals and applies to all patients and visitors.

As a patient seeking our care, we expect you to:

- Provide accurate, complete, and current health information to your healthcare team.
- Participate in your health care by helping make decisions, following the treatment plan prescribed by your clinician, and accepting responsibility for your choices.
- Ask questions and seek clarification to understand your health problems and participate in mutually agreed upon treatment goals.
- Keep scheduled appointments/procedures and notify the provider's office promptly if you are delayed or cannot keep an appointment (charges may be incurred for missed appointments that are not cancelled or modified 24 hours in advance).
- Know the benefits and exclusions of your health insurance coverage.
- Make payment of all services or non-covered services and applicable co-payments at the time service is provided
- Do not photograph or record anyone without permission. This includes all staff/employees, our facilities, equipment, or Protected Health

As a patient seeking care from Vida Dermatology and Aesthetics, we rely on your cooperation so you can achieve the best clinical outcomes, and so we can operate our offices efficiently. Please know that continued violations of this Patient Code of Conduct may result in discharge from the practice, legal action to collect payment, or other possible consequences.

The following behaviors are PROHIBITED and may be grounds for discharge from the practice:

1. Possession of firearms or any weapon (Exception: active-duty law enforcement officer in accordance with departmental policy).

2. Physical of verbal threats, assault, or inflicting bodily harm.

3. Throwing objects and/or destroying property.

4. Using profanity, a raised and/or hostile tone of voice, or the use of menacing gestures.

5. Attempting to intimidate or harass others.

6. Making offensive, disrespectful, or discriminatory comments about others' race, accent, religion, gender, gender identity, sexual orientation, or other personal traits.

7. Using or being under the influence of non-prescribed drugs or alcohol.

8. Smoking vaping on the premises; we are a smoke-free facility.

Our practice follows a zero-tolerance policy for noncompliance with this Code of Conduct and may result in your being discharged from the practice. Potential criminal violations may result in referrals to law enforcement authorities for further investigation and possible prosecution.

- If you have any questions about your care, this document, or are not satisfied with the services received in our office, please ask to speak with the office manager so that any of your questions can be addressed.

I certify that I read, understand, and will comply with this Patient Code of Conduct. I acknowledge that failure to do so may result in discharge from Vida Dermatology and Aesthetics or other possible consequences as stated above.

Name _____

Sign _____

Date ____/____/_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE NURSE PRACTITIONER. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

REFERRALS - If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

CO-PAYMENTS - By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit.

OUT OF NETWORK PLANS - You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form.
When the provider you are scheduled to see does not participate with your insurance, your plan may not cover out-of-network services, leaving you to pay the full cost. If your plan does cover out-of-network services, you may be assessed a higher co-pay, deductible and co-insurance for out-of-network care. You will be responsible to pay these higher amounts plus any difference between the allowed amount and the amount the out-of-network provider charges for the service.
Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Vida Dermatology and Aesthetics for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SELF-PAY PATIENTS - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE - We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Vida Dermatology and Aesthetics for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services.
This information will be used for the purpose of evaluating and administering claims of benefits.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS

- The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Vida Dermatology and Aesthetics LLC will not be involved with separation or divorce disputes.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR AMERICAN EXPRESS CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I grant permission and consent to the Practice to (a) leave voicemail messages for me, including information regarding amounts owed by me; (b) send me text messages using any wireless telephone numbers I provide; (c) send me e-mails - including unencrypted emails - using any e-mail addresses I provide; and (d) use pre-recorded/artificial voice messages and/or automatic dialing device in connection with any communications made to me. I understand such calls or contacts could result in charges to me depending on my wireless telephone service plan. The Practice will not be liable for any such charges associated with contacting me as set for above

I agree to the following conditions:

- I agree to allow Vida Dermatology and Aesthetics LLC to automatically charge my credit card(s) on file for balances due for medical services rendered, in the amounts determined by my insurance company and/or the practice for each transaction.
- My credit card(s) will be stored by a secure payment processor that partners with Vida Dermatology and Aesthetics LLC to collect payments. My credit card number(s) will be encrypted and will not be visible to any users within the practice.
- I will receive a receipt for any charges to my card(s).
- All transactions will be in US dollars, unless otherwise noted.
- I may cancel this agreement at any time by contacting Vida Dermatology and Aesthetics LLC If you have any questions relating to this agreement or any charges, please contact Vida Dermatology and Aesthetics LLC

Name _____

Sign _____

Date ____/____/_____