



TOTAL  
LIPDEMA  
CARE

## NEW PATIENT WELCOME FORM

**Welcome to our practice!** We are honored you have chosen Dr. Jaime Schwartz, Dr. Karen Herbst and Total Lipedema Care. We are committed to making your experience with us the finest possible. We respect your time and will do whatever we can to stay on schedule. We realize circumstances may keep you from your scheduled appointment, therefore:

**Please be on time.** If you arrive more than 15 minutes late, it is likely we will need to reschedule your appointment for a later time or date. This allows us to give each patient our undivided attention. If you need to cancel your appointment, please do so 24 hours in advance. Existing patients who do not show up to their appointment will be charged a \$100 no-show fee, which can be credited towards any procedures or products here in the office.

**We collect a consultation fee at the time of scheduling to secure your appointment time. The consultation fee is non-refundable.**

**My signature below certifies that I have read and understand this agreement**

**Name**

Angela Atchley

**Signature**

**Date**

Thursday, August 31, 2023 10:50

## AGREEMENT AS TO RESOLUTION OF CONCERNS

"Provider" shall be understood to mean Dr. Jaime Schwartz and Dr. Karen Herbst

- I understand that I am entering into a contractual relationship with the provider for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the provider, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any merit less or frivolous claims of medical malpractice against the provider.
- Should I initiate or pursue a meritorious medical malpractice claim against provider, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Plastic Surgery.
- Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Plastic Surgery.
- I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Plastic Surgery.
- I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration, the provider also agrees to exactly the same above referenced stipulations.
- Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or merit less claim.
- Patient/guardian and provider agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.
- Provider and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of

recovery.

- Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

**My signature below certifies that I have read and understand this agreement:**

**Name**

Angela Atchley

**Signature**



**Date**

Thursday, August 31, 2023 10:50

## PRIVACY PRACTICES

### NOTICE OF PRIVACY PRACTICES

Effective Date: 02/26/2016

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

#### **A. How This Medical Practice May Use or Disclose Your Health Information**

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

**1. Treatment:** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

**2. Payment:** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

**3. Health Care Operations:** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their

health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available upon request from our office.

**4. Appointment Reminders:** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone

**5. Sign In Sheet:** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

**6. Notification and Communication with Family:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they

may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

**7. Marketing:** Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face to face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14 point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

**8. Sale of Health Information:** We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

**9. Required by Law:** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

**10. Public Health:** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

**11. Health Oversight Activities:** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

**12. Judicial and Administrative Proceedings:** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

**13. Law Enforcement:** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

**14. Coroners:** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

**15. Organ or Tissue Donation:** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

**16. Public Safety:** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

**17. Proof of Immunization:** We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

**18. Specialized Government Functions:** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

**19. Worker's Compensation:** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

**20. Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**21. Breach Notification:** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

**22. Psychotherapy Notes:** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law

requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

**23. Research:** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

**24. Fundraising:** We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify our office listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify our office if you decide you want to start receiving these solicitations again.

#### **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

#### **C. Your Health Information Rights**

**1. Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

**2. Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

**3. Right to Inspect and Copy:** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred

to another mental health professional.

**4. Right to Amend or Supplement:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

**5. Right to an Accounting of Disclosures:** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our office.

#### **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our office. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX - Office for Civil Rights  
U.S. Department of Health & Human Services  
90 7th Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX  
OCRMail@hhs.gov

The complaint form may be found at:  
[www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)  
You will not be penalized in any way for filing a complaint.

## **ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

- I consent to use or disclosure of my protected health information by Dr. Jaime Schwartz and Total Lipedema Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I understand that diagnosis or treatment of me by Dr. Jaime Schwartz or Total Lipedema Care may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Jaime Schwartz or Total Lipedema Care is not required to agree to the restrictions that I may request. However, if Dr. Jaime Schwartz or Total Lipedema Care agrees to a restriction that I request, the restriction is binding on Dr. Jaime Schwartz or Total Lipedema Care. I have the right

to revoke this consent in writing, at any time, except to the extent that Dr. Jaime Schwartz or Total Lipedema Care has taken action in reliance on this consent.

- I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices, as requested. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment, as requested.

**My signature below certifies that I have read and understand this agreement:**

**Name**

Angela Atchley

**Signature**



**Date**

Thursday, August 31, 2023 10:50

## **FINANCIAL POLICIES**

### **PROCEDURE SCHEDULING**

- A \$5000.00 non-refundable deposit is collected to hold a surgery date.
- The remaining balance for surgery is due in full 30 days prior to your surgery date. If you cancel your surgery date within 30 days of the scheduled date, or if your surgery is rescheduled due to non-compliance with pre-surgical requirements, your total fees will be non-refundable.
- Once services are rendered or products sold, there are no refunds. Surgery and non-surgical procedures come with no warranty (guaranteed or implied) of any certain result. Perceived lack of improvement in one's condition or outcome does not translate into any type of refund.

### **INSURANCE COVERAGE AND CHANGES**

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- If you have had any changes in your insurance coverage, you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.
- Cosmetic procedures & surgery is not a benefit that is paid by most health insurance plans.
- All patients are responsible for "non-covered" services if denied by their insurance carrier.
- Please see our insurance agreement form for further information

### **CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES**

- Coinsurance and copayments are the patient's financial responsibility. They are due at the time of visit.
- Deductibles are patient's financial responsibility. The deductible is determined by the contract you have with your insurance carrier.

### **INSURANCE PAYMENTS**

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.
- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will become responsible for payment.

### **LABS/PATHOLOGY**

- If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. Lab or Pathology charges are separate charges from our office charges, and you are financially responsible for them.

### **REFUNDS**

- Refunds are subject to approval and are approved at the sole discretion of the business.
-

Refunds will be completed in the same method that initial payment was made. If payment is made using a credit card, then the refund must go back to the same card used for payment.

- Refunds will be less the Credit Card Merchant processing fee of 3.5%.
- Once requested, refunds can take up to 30 days processing time.

**Name** Angela Atchley

**Signature**



**Date** Thursday, August 31, 2023 10:50

## CONSENT FOR EMAIL/TEXT COMMUNICATIONS

"Provider" shall be understood to mean Dr. Jaime Schwartz, Dr. Karen Herbst, Total Lipedema Care and Staff.

Electronic communication is a form of communication using "secure" Web sites, text messaging or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication along with telephone, mail, and in-person. It is meant to replace other forms of communication with the doctor. I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Dr. Jaime Schwartz, Dr. Karen Herbst, Total Lipedema Care, TLC Surgical Center and Staff ("Practice") by alternative means or at alternative locations.

**How we will use Electronic Messaging: We may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:**

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services.
- how to participate in patient satisfaction surveys or how to use our secure patient portals
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.
- information about upcoming procedures and medical communication

**Conditions for the use of Electronic Messaging:**

- The provider cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:
- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using electronic communication, regular telephone or our secure patient portal.
- Electronic Messaging may be filed into your medical record.
- The Provider is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

**Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:**

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

**Release:** In consideration of The providers services and my request to receive Electronic Messaging as described herein, I hereby release The Provider from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

- I have received and reviewed the above notice; had an opportunity to ask questions and have had such questions answered to my satisfaction; and understand the information contained within the notice.
- Despite the possibility that any electronic communication system or text system may not be encrypted or secure and there are no assurances of confidentiality, I consent to the Practice communicating with me with these systems.
- The email address and phone number I provided in my patient account is accurate and it is my responsibility to update the Practice of any changes.
- I may withdraw this consent at any time by delivering written notice to the Practice.
- Alternative methods of communication (i.e., telephone, in-person, mail) are still available to me.
- I am responsible for taking steps to protect myself from unauthorized use of online communication.
- The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.
- I understand that online communication should not be used for emergencies or time sensitive matters.
- I understand that it is my responsibility to determine if an unanswered online communication was received.
- My healthcare provider and I have agreed to correspond using electronic mail (e-mail).
- My healthcare provider and I have agreed to correspond using other online applications (Klara & Modernizing Medicine).
- This form provides guidelines for the intended use of this type of communication and documents my consent.

**I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between The Provider and me, and I consent to the conditions and instructions outlined, as well as any other instructions that The Provider may impose to communicate with me by Electronic Messaging.**

**Name**

Angela Atchley

**Signature**

A handwritten signature in black ink that reads "Angela Atchley". The signature is written in a cursive, flowing style.

**Date**

Thursday, August 31, 2023 10:50