POLARIS FAMILY MEDICINE

CONSENT TO TREAT AND HEALTHCARE AGREEMENT

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed by my provider(s) or their designee. I understand that Polaris Family Medicine PLLC may include teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care. I understand that this Consent to Treat will be valid for each visit I make to Polaris Family Medicine PLLC until revoked by me in writing.

Consent to Release Information: I acknowledge that Polaris Family Medicine PLLC may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that the Notice of Privacy Practices provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS. I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure, I may be required to pay the entire cost of medical care provided by Polaris Family Medicine PLLC. I acknowledge and consent to allow Polaris Family Medicine PLLC to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other protected health information.

No Show and Late Cancellation Policy: Patients may be subject to a $50.00 fee for no show and $25.00 for late cancellation with less than 24 hours notice. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

ComprehensiveCare Support Fee: I understand that Polaris Family Medicine charges an annual Comprehensive Care Support Fee (set yearly and available on organization website), which enables the practice to provide personalized, unhurried care beyond what insurance covers. I acknowledge that this fee is separate from insurance-covered services and agree to pay this annual fee as part of my enrollment with the practice. I understand that this fee helps maintain the high-quality, individualized care that Polaris Family Medicine provides to its patients.

Assignment of Insurance Benefits/Patient Financial Responsibility: I assign and transfer to Polaris Family Medicine PLLC all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance for services rendered. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and accept financial responsibility for any charges incurred from services rendered

during any visit which is not covered by my insurance company. I understand and agree that I will be responsible for any deductible, co-pay or balance due that I may be required to pay under my insurance or that Polaris Family Medicine PLLC is unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses. I authorize Polaris Family Medicine PLLC to securely store my credit card information on file and charge my card for any outstanding balances, co-pays, deductibles, or other fees related to my medical care after appropriate notice has been provided.

Medicare/Medicaid/Insurance Benefit: If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Polaris Family Medicine PLLC on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

Lab/X-ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Polaris Family Medicine PLLC or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

Telemedicine Consent: I understand and consent to receiving healthcare services through telemedicine technology, including video conferencing and secure messaging platforms. I acknowledge that while telemedicine offers convenience and increased access to care, there are potential risks including technology failures, privacy concerns, and limitations in physical examination that may affect diagnosis and treatment decisions.

Scribe Services: I consent to audio recording of my medical appointments for the purpose of clinical documentation and note-taking through ambient scribe technology, understanding that these recordings are used solely for accurate medical record creation and are handled in compliance with HIPAA privacy regulations.

Consent to Photograph/Digital Imaging: I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that Polaris Family Medicine PLLC will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

Accidental Exposure of Health Care Worker: I give consent, that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Notice of Financial Policy: I acknowledge receipt of the Financial Policies from Polaris Family Medicine PLLC.

Notice of Privacy Practice: I acknowledge receipt of the Notice of Privacy Practices from Polaris Family Medicine PLLC.

Patient/Responsible Party Signature Date