Kolbe Medical
Nicholas Boggs, DO PLLC

Patient Informed Consent

Consent to Medical Care and Treatment: I hereby consent Kolbe Medical (inclusive of Nicholas Boggs, DO PLLC) and its physicians, advanced practice providers, assistants, and designees (collectively called “Providers”) to provide medical, behavioral, and psychological care and/or any other services to me either in person or remotely as deemed necessary. In addition to the Providers, other professional personnel, including affiliate consultants, trainee students and vendors may be in attendance during treatment services. I may decline their attendance at any time during care. I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures. I authorize Kolbe Medical to dispose of the bodily fluids. A drug screen by blood or urine sample may be obtained with verbal consent for the purpose of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist or surveillance for Compliance/Diversion.

1. Consent to Use Information: I understand that as part of my health care, Kolbe Medical collects Protected Health Information (“PHI”) which includes, but is not limited to, my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future treatment. I understand that my medication history and formulary benefits may be downloaded from a secure electronic clearinghouse. I also understand and accept that every effort will be made to protect my PHI, and that breaches may occur. I fully release and agree to hold harmless Kolbe Medical, its Physicians, and its affiliates from any claim for damages resulting from such breach. Furthermore, I acknowledge that my PHI is used for (i) planning my care Physicians and other health professionals providing my care, (ii) as a tool for assessing and reviewing Kolbe Medical routine health care operations, (iv) for billing purposes, including processing by third-party payers, and (v) for other purposes consistent with the Health Insurance Portability and Accountability Act (HIPAA) and treatment (iii) as a means of communication among this information serves as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

2. Receipt of Notice of Privacy Practices: I acknowledge that I have been offered a copy of Kolbe Medical’s Notice of Privacy Practices which provides information on how Kolbe Medical may use or disclose my PHI purposes of treatment, payment, or health care operations. The Notice of Privacy Practices is also located on the Kolbe Medical website.

3. Consent to Request Information: I consent to the following actions by Kolbe Medical with regard to my PHI: (i) request of my PHI from other providers of care to me, (ii) receipt of and release of my PHI, whether written, verbal, or electronic, for the uses described above and (iii)

Kolbe Medical's participation in any Health Information Exchange described in Kolbe Medical's of Privacy Practices.

4. Consent to Notify: Kolbe Medical has my permission to: (i) call my home or alternative contact and leave detailed messages via phone, voicemail, text, video, email, secure or unsecured, or in person pertaining to my health care: (ii) mail to my home or other alternative location any items that assist the practice Kolbe Medical in carrying out treatment, payment, and health care operations such as appointment reminder cards, and statements (iii) email the provided address to assist Kolbe Medical in carrying out treatment, payment, and health care operations, (iv) Send out appointment reminders via home phone, text, and or email; and (v) communicate via secure text message, email and/or video chat regarding patient care plans or other matters pertaining to my health. I acknowledge I can retrieve from the Kolbe Medical portal my medications and treatment history populating the Kolbe Medical portal is an integral part of Chronic Care Management.

5. Assignment of Benefits: I certify that the information provided by me in applying for payment by Medicare under TITLE XVIII of the Social Security Act or Medicaid or any other third-party payer is correct and request that all authorized benefits be accepted on my behalf.

6. Financial Responsibility: I hereby authorize and instruct my insurance carrier to make payments for my care directly to Kolbe Medical I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts. In order to provide the best care possible, substantial amounts of time are spent in chronic care management, care coordination, remote treatment and care plan oversight which may result in fees when performed in accordance with Medicare regulations.

7. Care Coordination/ Remote Treatment: I and my representatives give consent for any and all care coordination, care plan oversight, chronic care and behavioral health management including the use of e-visits, tele-visits, Telehealth, remote patient treatment or any other forms of care coordination past, present or future, with any associated charges. I agree that I will be responsible for any charges associated with such care coordination not covered by insurance, and I understand that I have the opportunity to opt out at any time. My consent to remote treatment, remote therapy, and monitoring that exists now or in the future allows Provider to obtain, via HIPAA compliant process, either by text, email or other wifi or internet based process with programmed alert transmission of salient data, either in person or electronically, to capture patient data such as vital signs, pain, glucose or other labs or clinical conditions. I agree to any Provider, caregiver, family, facility or other member of care team to obtain vitals or other clinical information or input existing vitals or data into EMR/other software portal as needed in lieu of other interactive methods which may be problematic or prohibitive. If my care coordination involves remote patient monitoring, I further agree that Kolbe Medical and its Providers and other members of my care team may obtain vitals and/or other clinical information from me and may input such data into an electronic medical record ("EMR") or other software portal as needed for my care, care coordination and billing Medicare, Medicaid, and other federal or state programs and payers. Although the patient may have deficits and unable to fully comply with 16

days and 30-day measurements, every effort is made, they should not be discriminated against, but supported, and every effort made and the ability to obtain data for those days in the best interest of patient, less frequent but more accurate and reliable methods/devices by agent/personnel/caregivers/care team or family.

8. Controlled Substance Policy: Many Kolbe Medical patients require controlled substances including narcotics and psychotropics, and Kolbe Medical will treat these patients on a case-by-case basis. Kolbe Medical reserves the right to be the sole provider of these medications and will attempt to wean them whenever possible. Non-compliance by a patient with Kolbe Medical's recommendation for proper use of controlled substances could result in termination of care. Kolbe Medical also treats many patients with cognitive deficits or dementia and reserves the right to treat behavioral issues with antipsychotic medications if needed for the safety and security of the patient or those around the patient. While treatment with these medications may have a slight increased risk of non-treatment for significant behaviors would often pose a greater risk. Kolbe Medical adheres to state and federal laws regarding the manner in which medications are prescribed, the amount prescribed, and the tracking and monitoring for compliance of these regulations.

I understand that I have the right to request that Kolbe Medical restrict how it uses or discloses my Personal Health Information to carry out treatment, payment, and healthcare operations. Additionally, I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I HAVE READ OR HAD THIS READ TO ME AND FULLY UNDERSTAND THIS CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THESE QUESTIONS ADDRESSED.

Patient Name (Print):_____________________________________
Date:______________________

Patient Signature: _______________________________________
Date:______________________