Patient Information and Consent

Welcome and thank you for considering Hometown Pediatric Dermatology PLLC (“Hometown Pediatric Dermatology”, “us”, “Company”, “Hometown Pediatric Dermatology PLLC”) for your health needs. This document contains important information about our professional services and business policies.

Physician

The undersigned professional is a physician. The physician is engaged in private practice providing health care services to clients directly or via licensed independent contractors of the licensed physician’s Company. In addition, as the owner and managing member, the undersigned physician provides all health services through Hometown Pediatric Dermatology PLLC and not personally.

Appointments

Appointments are made by calling 612-234-2331 during the normal business hours listed at hometownpediatricdermatology.com or online scheduling at hometownpediatricdermatology.com. You will receive a link for credit, debit or ACH for payment at time of scheduling. If payment is not received 1 week prior to scheduled appointment, your appointment slot is VOID and WILL BE GIVEN AWAY. You will not be charged. If you cancel within 1 week of your appointment, the payment is not refundable. If you do not come to your appointment (“no show”), the payment is not refundable. If you need to reschedule within one week of your appointment, and your slot cannot be filled, you may be responsible for payment." Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment and there will be no pro-rating of the fee. If the physician has to cancel the appointment, you will be entitled to a refund. Follow ups may be scheduled the same way as initial intake.

Prescriptions will be sent via electronic prescribing.

Off-label use of medications is common in dermatology. There are few, if any, FDA approved treatments for many dermatologic conditions. Risks of individual medications, in either on or off-label use, will be discussed as relevant with each patient.

Detailed patient instructions are typically given after each visit. These are for your reference, but if any questions or concerns arise regarding your care or medications, please contact Hometown Pediatric Dermatology.

When available, the patient portal may be used for non-urgent questions. While typical response time is approximately 24-48 hours M-F, it may be longer pending clinic operations or out-of-office time. For emergencies, 911 should be utilized and for urgent concerns, your primary care provider or urgent care are appropriate options.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the physician. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the undersigned physician will be able to provide you with some first impressions of what medical services may include and a treatment plan to follow if both you and physician agree to work together in medical services. You should evaluate this information along with your own opinions of whether you feel comfortable working with the physician. Medical services involve a large commitment of time, money, and energy, so you should be very careful about the physician you select. If you have questions about procedures feel free to discuss them with the physician at any time. If you have doubts, your physician will provide a list of other board certified pediatric dermatologists.

Length of Visits

New patient appointments range typically from 20-30 minutes, but may be longer based on medical or social complexity. Further evaluative sessions may be scheduled as needed for the physician to accurately assess your needs. Follow up appointments are typically scheduled for 20-30 minutes, but may be longer or shorter depending on complexity.

Relationship

Your relationship with the physician is a professional relationship. In order to preserve this relationship, it is imperative that the physician not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the doctor-patient relationship.

If the physician encounters you in public setting, in order not to reveal your identity the physician will not acknowledge your presence unless addressed by you first.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the physician.

Cancellations

Cancellations must be received at least 1 week before your scheduled appointment; otherwise you may be charged the session fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Payment for Services

You are responsible for the fees for services due at the time of your appointment. The current fees are provided in the fee schedule. These fees are subject to change and will be provided to you at your scheduled appointment. You may always visit the website for the most updated fee schedule. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated and you may be given referrals to other competent providers. The undersigned physician does not normally accept assignment of insurance benefits but may be required to do so in connection with certain managed care contracts. The undersigned physician will look to you for full payment of your account, and you will be responsible for payment of all charges at the time of service. Different copayments are required by various group coverage plans. Your copayment is based on the Health Policy selected by your employer or purchased by you. In addition, the copay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the undersigned physician's charges for services at the time the services are provided. It is recommended that you determine your copayment before your first visit by calling your benefits office or insurance company.

Although it is the goal of the undersigned physician to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the physician's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the physician at the time of the request or service of the subpoena (current rate is $450/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the physician. The physician may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

Mandated Reporting

Under Minnesota Law, persons in designated professional occupations are mandated to report suspected child abuse or neglect. Persons who work with children and families are in a position to help protect children from harm. These persons are required by law to report to child protection if they know or have a reason to believe that a child is being abused or neglected or that a child has been neglected or abused within the prior three years. As a mandated reporter, the

physician may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Medical services

There are no guarantees in medical services and the physician does not make any guarantees with this agreement. You assume the risk of medical services by signing this form. The physician is not liable for any adverse reactions to medical services. The physician may take any reasonable action necessary during medical services when there is a dangerous circumstance, as determined by the physician.

After-Hours Emergencies

Please know that your physician and Hometown Pediatric Dermatology PLLC do not provide twenty-four (24) hour crisis or emergency medical services services. Should you experience an emergency necessitating immediate health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Physician

Your physician is often not immediately available by telephone. The office number 612-234-2331 is answered by voice mail that the physician will monitor from time to time throughout the day. Although the physician is typically in the office during normal business hours s/he will not take calls when with a patient. A reasonable effort will be made to return any call made during normal business hours on the same day it is received, weekends and holidays excepted. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please indicate whether or not the physician may leave a message. If you are unable to be reached, a letter will be sent by U.S. mail.

Messaging

The undersigned physician and Hometown Pediatric Dermatology PLLC may use HIPAA compliant messaging systems to communicate with you. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails or any communications sent via Facebook, online and specifically the website hometownpediatricdermatology.com are not secure and you assume the risks of the insecure transmission.

Social Media

Your physician does not usually accept friend or contact requests from current or former patients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the physician and the patient. It can blur the boundaries of the professional relationship.

Physician's Incapacity or Death

You acknowledge that, in the event the undersigned physician becomes incapacitated or dies, it will become necessary for another physician to take possession of your file and records. By signing this information and consent form below, you give consent to allowing another licensed health professional selected by the undersigned physician to take possession of your file and records and provide you with copies upon request, or to deliver them to a physician of your choice. The undersigned physician will select a successor physician within a reasonable time and will notify the appointed licensed health professional.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned physician will record any part of your sessions unless you and the physician mutually agree that the session may be recorded. You further acknowledge that the undersigned physician objects to you recording any portion of your sessions without the physician's consent. You expressly agree that audio and video recordings used for security purposes are not part of medical services, and are therefore not protected by confidentiality or any other provisions under this agreement.

Distance Medical services (Telehealth)

Distance medical services includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications, including email. This is sometimes referred to as “Tele-medicine” or “Tele-health”.

Identity Verification

You may be expected to provide a copy of your driver's license and other identity verifying documentation requested by the undersigned physician before any distance medical services are provided.

Privacy and Security of Communications

All electronic communications between you and the undersigned physician will be transmitted using reasonable measures to ensure confidentiality. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication.

Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned physician when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

Risks Associated With Distance Medical services

There are privacy and security risks and consequences associated with distance medical services despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in telehealth and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the undersigned physician to arrange a secure line of communication.

Distance medical services may not be appropriate for every medical situation. The undersigned physician will continually assess the appropriateness of distance medical services for you. If the undersigned physician determines that you would be better served by receiving different evaluations, such as a face-to-face evaluation, the Company will be clear about the level of urgency for a particular service and which type of provider may be involved. Referrals will be offered when they are appropriate.

Communication Interruptions

If you are unable to connect with the undersigned physician or are disconnected during a session due to a technological breakdown, please try to reconnect . If reconnection is not possible, we will reschedule the visit if needed to complete the plan of care. If the plan of care is clear, other methods of communication may be used to confirm the visit is complet. The physician can be reached at the following phone number: 612-234-2331.

Consent to Treatment Using Distance Medical services

I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of HIPAA compliant software including but not limited to text, email, patient portals, and authorize the undersigned physician to provide such care, treatment, or services as are considered necessary and advisable.

By signing this Agreement, I, the undersigned patient, acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Minnesota as applied to contracts that are executed and performed entirely in Minnesota. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be Hennepin County or Ramsey County, Minnesota. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

Consent to Treatment

I, voluntarily, agree to receive (or agree for my child to receive) health assessment, care, treatment, or services, and authorize Hometown Pediatric Dermatology PLLC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Hometown Pediatric Dermatology PLLC at any time.

By signing this Client Information and Consent form, I, the undersigned patient (or parent/guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my physician.

Client/Parent/Guardian 1 Signature: ____
Date: ________________

(OPTIONAL) Parent/Guardian 2 Signature: ____
Date: ________________
(If client is a minor and parents are separated)

[MINORS ONLY next 3 page] - Minor Consent for Treatment Form

Individuals under the age of 18 cannot be treated for health related services without consent. Exceptions to this are governed by Minnesota Statutes, Chapter 144. Exceptions are summarized below and all other treatment requires parental / guardian consent. In signing below I give the Company permission to treat my son/daughter. I may revoke this consent at any time with written notice to the Company.

Conditions When Parental Consent Is Not Needed For Treatment of Minors

144.341 Living apart from parents and managing financial affairs, consent for self.

Notwithstanding any other provision of law, any minor who is living separate and apart from parent(s) or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

144.342 Marriage or giving birth, consent for health service for self or child.

Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

144.343 Pregnancy, venereal disease, alcohol or drug abuse, abortion.

Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

144.344 Emergency treatment.

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. 144.3441 Hepatitis B vaccination. A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

144.345 Representations to persons rendering service.

The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

144.346 Information to parents.

The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

144.347 Financial responsibility.

A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.

Parental / Legal Guardian Consent:

I give Company permission to treat:

_________________________________ ________________________ ____________________

Full Name of Minor Child Social Security Number Date of Birth

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at the Company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above named individual reaches the age of 18 or meets any of the conditions identified above.

Client/Parent/Guardian 1 Signature: ____

Date: _________________

Parent/Guardian 2 Signature: ____

Date: _________________

(If client is a minor and parents are separated)

Consent for communication with caregivers for patients 18 and over:

You consent to allow the Company to coordinate care with your primary care provider, parent, guardian, or medication provider, and your consent to this agreement authorizes Company and its agents to contact the primary care provider, parent, guardian or medication provider on your behalf, as contemplated under the core health care activities of “Treatment,” “Payment,” and “Health Care Operations” as defined in the Privacy Rule at 45 CFR 164.501.

Client/Parent/Guardian 1 Signature: ____
Date: ________________

Parent/Guardian 2 Signature: ____
Date: ________________
(If client is a minor and parents are separated)