Latitude Clinic LLC

New Pediatric Registration, History and Consents

Child's First Name _____ Child's Last Name _____

Date of Birth _____ Sex _____

Email _____

Mobile Phone_____Home Phone _____

Address _____

City _____State _____Zip Code _____

Purpose of this visit _____

How did you learn about our office _____

Emergency Contact Information

First Name _____Last Name _____

Phone Number _____Relationship _____

Disclosures to Other Family Members or Friends

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR CHILD'S (OR YOUR) MEDICAL CONDITION? IF YES, WHOM?

I give permission for my child's (or my) Protected Health Information to be disclosed for the purposes of communicating results, findings and care decisions to the family members and others listed below:

Name _____ Relationship_____

Phone Number _____ Address _____

Name _____ Relationship_____

Phone Number _____ Address _____

Current or Recent Health Care Providers _____

_____

Preferred Pharmacy _____

If this is Baby's first visit, please list place of birth: _____

_____ Yes, I give permission for Latitude Clinic to request birth records prior to first visit

_____ No, I prefer that Latitude Clinic does NOT request birth records prior to first visit

Allergies

Do you have any drug allergies? _____

If yes, please list including reaction _____

Birth History

Full Term (>37 wks)? _____ Mom's Age(weeks) at time of delivery_____

Delivery: _____ Vaginal _____ C-section Birth Complications;_____

Birth Weight _____ Apgar Score at 1 min _____ Apgar Score at 5 min _____ Jaundice? _____

Problems during Pregnancy? _____

Adopted _____ Foster _____ Legal Guardianship _____ If yes, access to child's Family History? _____

Miles Stones:

Age in months for: Rolling Over _____ Sitting Up _____ Standing _____ Walking _____
Talking _____ Potty Trained _____
Difficult to console during the first month of life? _____

Complications during the First Month of Life _____

_____

_____

_____

Concerns for Development Delay? If Yes, age of onset, Please explain the concern: _____

_____

_____

_____

Medical History

Has your child ever been hospitalized? Why / When: _____

_____

_____

Please List Current and Past Medical History _____

_____

_____

Any antibiotics in the last 6 months? _____

Surgical History

Please list previous surgeries and the month/year they were performed _____

_____

_____

Significant Family History _____

_____

Did any family member die younger than age 50 (excluding accidents), if yes, please explain _____

_____

_____

Current Medications: _____

_____

_____

Environmental History

_____ 2nd Hand Smoke _____ Pets in the home _____ Mold in the house _____ Day Care

_____ Well Water _____ Traveled outside the country in the last two years

Has your child experienced any major life changes or losses? _____

Number of hours of sleep a night _____ Does the child awake feeling rested? _____

Nutrition

Infants /Toddlers: _____ Breastfed _____ Formula, if yes, type and amount _____

Dietary Restrictions _____

Type of diet (typical) _____

Does your child have Lead exposure? _____ Have a place to live? _____ Wear a seat belt? _____
Feel safe at home? _____ Wear a helmet for sports?_____ Know how to swim? _____

Parents marital status _____ Who does the child live with _____
_____

Who are the people caring for your child? (family, baby sitter, daycare) _____
_____

Adolescent Health

Started menses? _____ Age of first menses _____ Date of last menses _____
Frequency of menses _____ Length of menses in days _____ Are menses painful? _____ Heavy?_____
Is there a history of vaginal infections? _____ Using birth control? Method? _____

Are Immunizations up to date? _____
Please attach or bring record or exemption to first visit if applicable

Regular Dental Appointments? _____ Physical Activity? _____

Sexually active? _____ If yes, with ___ Male _____ Female _____ Both Using Contraception? _____

Do you smoke?	Packs/Day	# of Years	If past, date quit
Yes. No	_____	_____.	_____

Do you drink alcohol? If yes, How much? _____

Do you drink Caffeine? If yes, How much? _____

Do you use Recreational Drugs currently or in the past? If yes, what and when, current or past?
_____
_____

Good Faith Estimate For Uninsured or Self-Pay Individuals

Patient's First Name _____ Patient's Last Name _____

Date of Birth _____ Date _____

This is a Good Faith Estimate of the costs that you may anticipate for the primary service date noted below. You may pay more or less than the amount listed below. This is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to you. Actual items, services, or charges may differ from this estimate. There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

Provider Name: Vanessa Hamalian APRN or Sonya Merritt APRN and/or any other Health Care Provider employed by Latitude Clinic LLC
Provider NPI: Vanessa Hamalian 1265774186 or Sonya Merritt: 1174657456
Practice Tax ID: 86-2028456
Location of Service: 2831 Ringling Blvd, Suite F220, Sarasota FL 34237 or Virtual Visit

Primary Procedure/Service Booked	CPT Code	Estimated Cost
Classic Visit (40 min) for New pediatric patient up to 3 mo old	CPT 99203	$185
Classic Visit (40 min) for Pediatric patient with mult problems / Hospital Follow up	CPT 99214	$185
Concise Visit (20 min) Pediatric patient with no complex problems OR School Physical OR Sports Physical OR Note for School or Work OR Medication refill Lab orders/lab review	CPT 99213	$95
Virtual Visit after hours/weekend	CPT 99423	$185
Strep Test	CPT 87880	$15

Practice Subtotal: Range from $95 to $185

In addition to items and services provided by our practice, there may be items or services delivered by a third party in conjunction with the care we provide. Below are the estimated costs of these associated items and services.

Procedure/Service Booked	Service Provider	CPT/Diagnostic Code(s)	Cost
Biopsy per piece	Bayshore Pathology	11102	$100*
Complete Blood Count	Labcorp	85025	$10*
Complete Metabolic Panel	Labcorp	80053	$10*
HgA1c	Labcorp	83036	$11*
Lipid Panel	Labcorp	80061	$11*
TSH	Labcorp	84443	$10*

Third Party Subtotal: Range from $0.00 to $100, *subject to change
Estimated Item/Service Total: Range from $85 to $500

The following is a list of items or services that we anticipate will require separate scheduling and that are expected to occur following the expected period of care for the primary item or service listed above. Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services. For items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services. You may obtain good faith estimates for these items or services by sending a request in writing to ringling@latitudeclinic.com or visit www.latitudeclinic.com for additional pricing and information.

Your rights: If the actual billed charges are substantially in excess of the expected charges included in this estimate (at least $400 more than is listed here), you have the right to initiate the provider-patient dispute resolution process as specified in 45 CFR § 149.620. You have 120 calendar days from the date on your bill to begin the process. You can find information on how to initiate the patient-provider dispute resolution process at https://www.cms.gov/nosurprises. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to you.

NOTE: This Good Faith Estimate is NOT a contract and does not require you to obtain the items or services from any of the providers or facilities identified in this estimate.

NOTE: Latitude Clinic CANNOT provide the following services:

- Transfer out of State Vaccine Records to FL-Shots, this needs to be done at the (Sarasota County Health Department) Please call 941-861-2784 to schedule.
- Give "blanket" medical vaccine exemptions, we can only give medical exception for the same vaccine that the patient had a documented adverse reaction to, and we need records of the adverse event.
- Give Religious Vaccine exemptions- this is done at the SCHD (Sarasota County Health Department) Please call 941-861-2784 to schedule.
- Manage chronic pain with opioids
- Complete Disability Exams / Paperwork

Initial here to indicate that you have read and agree to the "Good Faith Estimate For Uninsured or Self-Pay Individuals"

I have received the Good Faith Estimate and have had the opportunity to ask questions

Signature _____ Date _____

Fee For Service Agreement

THIS FEE-FOR-SERVICE AGREEMENT ("Agreement") is entered into on ("Effective Date") by and between Latitude Clinic, located at 2831 Ringling Blvd, Suite F220, Sarasota FL 34237 ("Practice"), and ("Patient"). Practice and Patient may be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

WHEREAS, Practice provides Pediatric and Family Primary Care Medical Services and delivers personalized care, as enumerated in Attachment A, Fee Schedule, incorporated herein by reference; and

WHEREAS, Patient, according to the terms of this Agreement, desires to contract with Practice to obtain such services and care.

NOW, THEREFORE, in consideration of the foregoing recitals, which are incorporated as covenants, and the mutual promises herein made and exchanged, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

AGREEMENT

1. Definitions. Throughout this Agreement, the following terms shall have the following meanings:

(a) "Practice" shall mean Latitude Clinic, together with any and all of its medical practitioners.

(b) "Patient" shall mean the individual (or individuals) specifically scheduling this visit and documented on the appropriate

Client Intake Form(S). If one or more minors, incapacitated persons or persons subject to a power of attorney are documented on the appropriate client intake form(S), "Patient" shall include, jointly and severally, the parent, legal guardian, or surrogate decision maker of the Patient.

(c) "Services" shall mean those services specifically enumerated in Attachment A and shall exclude any and all other services not specifically enumerated, including, but not limited to, specialized services, emergency services, prescriptions, supplements, lab work, x-rays, ultrasound, MRI or those services Practice is not equipped, licensed or otherwise capable of providing.

2. Fees. In consideration for the Services provided, Patient agrees to pay Practice the amount(S) as set forth in Attachment A. This fee is due at the time Services are rendered. The Parties agree that the fee payable herein is fair market value for the specific Services rendered. Practice reserves the right to discontinue providing Services to Patient upon Patient's failure to pay any fees pursuant to this Agreement.

3. Collections Policy. In the event of nonpayment, Practice reserves the right to turn your account over to a collection agency or attorney in order to obtain payment of fees owed. Patient will be discharged from practice for nonpayment as per office policy. Return to the practice may be allowed on a case by case basis after delinquency is resolved.

4. Non-Participation in Insurance. Patient understands and acknowledges that Practice does NOT participate in any private or government funded health insurance, PPO or HMO plans or panels and is not accepting Medicare or Medicaid. Practice shall not submit bills to any government or private insurer or federal or state health care program (including Medicare, Medicaid, Tri-Care, Veterans Affairs, Federal Employee Health Benefits, etc.) for Services even if deemed to be a covered service under such third party insurance plan, and acknowledges that neither Practice nor its professionals will bill any third-party health insurance plan for the Services provided to Patient. Patient shall, therefore, remain fully and completely responsible for payment to Practice. Practice does not make any representation or warranty whatsoever that any fees paid under this Agreement are covered by Patient's health insurance or other third-party payment plans applicable to the Patient. Practice may provide receipts for services known as superbills. Patient may submit such superbills to any private insurer or federal or state health care program (including Tri-Care, Veterans Affairs, Federal Employee Health Benefits, etc.) for Services subject to the limitations of the policies

and procedures of those third-parties. Patient may NOT submit superbills to Medicare. Patient hereby represents and warrants that Practice has advised Patient to either obtain or keep in full force such health insurance policy(ies) or plan(s) that will cover Patient for general health care costs. Patient acknowledges that this Agreement does not cover hospital services, or any services not personally provided by Practice.

Medicare Beneficiaries: Despite what is written in the paragraph above, if Patient is subject to a Medicare Private Contract with Practice or Advanced Beneficiary Notice provided by Practice, Patient understands that any Medicare Private Contract or Advanced Beneficiary Notice take precedence and Patient agrees to abide by those documents where those documents conflict with this Section 4.

5. Private Contract. If Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient agrees to sign a Private Contract in the form designated by Practice. To the extent required by law, Patient agrees to enter into a renewed Private Contract every two (2) years, as requested by Practice.

6. Communications. Patient understands and agrees that e-mail communications (outside of the secure patient portal), facsimile, video chat, instant messaging, and cell phone are not guaranteed to be encrypted, secure or confidential methods of communications. Patient agrees that any communications made outside of the patient portal are made at Patient's risk with respect to all e-mail communications. Patient understands that use of electronic communication outside of the secure patient portal has inherent limitations, including possible breach of privacy or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

Practice may not respond to e-mails or other messages that contain sensitive medical information. If a response is requested, Practice may respond through the secure patient portal. Though it is Practice's policy only to respond through the patient portal regarding sensitive medical information, by initiating correspondence through an unsecure and/or unencrypted channel, Patient hereby expressly waives Practice's obligation to guarantee confidentiality with respect to correspondence using such means of communication. Patient understands and acknowledges that Practice may retain any communications between Practice and Patient and include such communications in Patient's medical record.

Patient understands and agrees that portal messaging or e-mail are not appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation which Patient reasonably believes could develop into an emergency, Patient shall call 911 or proceed to the nearest emergency room, and follow the directions of emergency personnel.

Practice checks telephone and portal messages during business hours and responds to them on a regular basis throughout the week. Portal messages are to be used for non-urgent messages only, and a response will generally be sent within three business days. By leaving a telephone or portal message, Patient acknowledges and agrees that a prompt reply is NOT required or expected and acknowledges that Patient will not use portal messages to deal with emergencies or other time sensitive issues.

Practice expressly disclaims any liability associated with any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of any action, inaction, technical issues, or activity outside Practice's control, including but not limited to, (i) technical failures attributable to any Internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address portal messages, (iii) failure of Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third-party; or (v) Patient's failure to comply with the guidelines regarding use of e-mail communications set forth in this Section.

7. Practice is NOT an urgent care or emergency service provider. If Patient encounters a medical emergency and is not able to obtain care from Patient's primary care physician(S), Patient shall contact 911 or report to a hospital emergency department as appropriate.

8. Change of Law. If there is a change of any law, regulation or rule, federal, state or local, ("Applicable Law") which affects this Agreement, or the duties or obligations of either Party under this Agreement, or any change in the judicial or administrative interpretation of any such Applicable Law, and Patient reasonably believes in good faith that the change will have a substantial adverse effect on his/her rights, obligations or operations associated with this Agreement, then Patient may, upon written notice, require Practice to enter into good faith negotiations to renegotiate the terms of this Agreement. If the Parties are unable to reach an agreement concerning the modification of this Agreement within forty-five (45) days after the date of the effective date of change, then either Party may immediately terminate this Agreement by written notice to the other Party.

9. Severability. If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of this Agreement shall not be affected. Any invalid or unenforceable provision shall be modified to the minimum extent necessary so as to remove the basis for invalidity or unenforceability.

10. Amendment. No amendment of this Agreement shall be binding on Practice unless it is made in writing and signed by Practice. Practice may unilaterally amend this Agreement, to the extent permitted by Applicable Law, by sending Patient a thirty (30) day advance written notice of any such change. Any such changes are hereby incorporated by reference into this Agreement without the need for signature of Patient and are effective as of the date established by Practice, except that Patient shall initial any such change upon Practice's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

11. Assignment. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient. Practice may assign this Agreement in whole or in part provided Practice provides Patient with written notice of such assignment. To the extent Practice assigns this Agreement in whole or in part, the transferee or assignee shall enjoy and undertake the same rights and obligations herein as Practice has hereunder to the extent incorporated in such assignment. 12. Relationship of Parties. Patient and Practice intend and agree that Practice, in performing Services pursuant to this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and the United States Department of Labor, and Practice shall have complete control over the manner in which the Services are performed.

13. Legal Significance. Patient understands and acknowledges that this Agreement is a legal document that creates certain rights and responsibilities. Patient represents and warrants that he/she has had reasonable time to seek legal advice regarding this Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of this Agreement.

14. Force Majeure. Neither Party shall be liable to the other for the failure or delay in the performance of any of the obligations under this Agreement when such failure or delay is due, directly or indirectly, to any act of God, acts of civil or military authority, acts of public enemy, terrorism, fire, flood, strike, riots, wars, embargoes, governmental laws, orders or regulations, storms or other similar or different contingencies beyond the reasonable control of the respective Parties.

15. Miscellaneous. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the Party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text.

16. Entire Agreement. This Agreement contains the entire agreement between the Parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

17. Notice. All written notices are deemed received by Practice if sent to the address of Practice written above and by Patient if sent to the Patient's address appearing in the applicable client intake form(s), provided notice to either Party is sent by Certified U.S. Mail, Return Receipt Requested. If Patient changes his/her address, Patient shall notify Practice promptly of his/her change of address.

18. Governing Law; Venue; Waiver of Jury Trial. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by binding arbitration. The demand for arbitration shall be made within a reasonable time after the claim, dispute or other matter in question has arisen, and in no event shall it be made more than two (2) years from when the aggrieved Party knew or should have known of the controversy, claim or dispute. The number of arbitrators shall be one. If the Parties are unable to agree upon the selection of an arbitrator within twenty-one (21) days of commencement of the arbitration proceeding by service of a demand for arbitration, the arbitrator shall be selected by the American Arbitration Association. The place of arbitration shall be Sarasota County, Florida and Florida law shall apply. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall pay its own proportionate share of arbitrator fees and expenses.

BOTH PARTIES EACH IRREVOCABLY WAIVE THE RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY LEGAL PROCEEDING RELATING TO THIS AGREEMENT.

Attachment A (Fee Schedule)

Fees for Services are as follows:

$185.00 Classic Visit is Defined as:

- New Adult Patient
- Adult Annual Exam with or without a PAP
- Adult Visit with 3 or 4 topics to Discuss
- Hospital Follow Up (Adult or Pediatric)
- New Pediatric Visit Under 3 months of age

$95.00 Concise Visit is Defined as: (concise visit may be increased to classic visit if additional time is required or additional topics need to be discussed $185)

- New Pediatric Patient (Age >3 months up to 17 years of age)
- DOT Exam OR School Physical
- Sports Physical without additional concerns to discuss
- Adult Visit, 18 years old and older, with 1-2 simple topics to discuss
- Pediatric Visit with 1-2 simple topics to discuss
- MAT follow up
- LDN Follow up
- TSM Follow up
- PAP $185.00

Sign here to indicate that you have read and agree to the "Fee for Service Agreement"

Signature _____ Date _____

Consent to Email and Text Usage for Appointment Reminders and other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which they may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Sign here to indicate that you have read and agree to the "Consent to Email and Text Usage for Appointment Reminders and other Healthcare Communications"

Signature _____ Date _____

Consent to Participate in Telemedicine Consultation

- (Hereinafter "I") seek the telemedicine consultation of Latitude Clinic ("Practice"). I am executing this Consent to Participate in Telemedicine Consultation ("Telemedicine Consent") to verify and confirm my discussion with Vanessa Hamalian APRN and/or Sonya Merritt APRN ("Provider") and/or any other Health Care Providers employed by Latitude Clinic LLC, regarding the risks, benefits, and alternatives to the telehealth consultation services through Practice. I am seeking the telemedicine consultation services of Practice for my own purposes and not on behalf of any third party. I understand that I am a participant in the decision-making process, and I am free to decline services or treatments at any time. I retain the option to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I acknowledge that Provider may, in his or her sole discretion, determine whether the nature of my consultation is inappropriate for telemedicine, and may require me to come in for an in-person consultation. I agree to bring to the attention of Practice, if, at any time, I have any lack of understanding of such risks, benefits, and alternatives, and inquire of Provider for further explanation until I have a full understanding before giving consent to any treatment or services.

1. Purpose. The purpose of this form is to obtain your consent for the use of telemedicine consultations with Provider. The purpose of the use of telemedicine consultations is to assist in the care and services provided by Practice and ultimately to assist in

2. Nature of Telemedicine Consultation. Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or educational purposes. During your telemedicine consultation, details of your medical history and personal history information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

3. Risks, Benefits and Alternatives. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. Additional benefits are that patients may be diagnosed and treated earlier which

can contribute to improved outcomes and less costly treatments. Potential risks of telemedicine include that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment.

Practice has taken the following steps to ensure the privacy of the telemedicine consultation:

- We use HIPAA compliant software through our Electronic Medical Record (EMR) software (Elation EMR), teleconferencing software (Zoom), and other electronic service providers as needed.
- We have taken steps to encrypt data stored on local devices
- We use password protected screen savers and data files
- We use other reliable authentication techniques and safeguards, both electronically and physically, to reduce the likelihood of patient data or privacy breaches

In rare instances, technology failure may lead to the loss of information provided through telemedicine consultations. Additionally, in rare instances, security protocols could fail causing a breach of patient privacy. In rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reactions, or other judgment errors. You agree to hold Provider and Practice harmless from any such information loss, and any resulting judgments or decisions, due to technological failures outside of their agency or control. The quality of transmitted data may also affect the quality of the services provided via the telemedicine consultation. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. Medical Information and Records. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation shall not occur without your consent.

5. Confidentiality. All existing confidentiality protections under federal and state law apply to information used or disclosed during your telemedicine consultation. However, there are both mandatory and permissive exceptions to confidentiality, which may allow or require disclosure of information used or disclosed during the telemedicine consultation. You will be informed of any parties who will be present from the Practice during your telehealth consultation and will have the opportunity to exclude anyone from attending the consultation.

6. Rights. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the right to be informed of and object to videotaping or other recording of the telehealth consultation.

By scheduling and appointment, I acknowledge and certify that:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I have had opportunities to ask questions and have had them answered to my satisfaction.
- I have read and fully understand the foregoing Telemedicine Consent, and I have all of the knowledge I currently desire.
- I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

Sign here to indicate that you have read and agree to the "Consent to Participate in Telemedicine Consultation"

Signature _____ Date _____

Private Contract

This Private Contract is entered into by and between Latitude Clinic LLC, with the primary located at 2831 Ringling Blvd, Suite F220, Sarasota FL 34237, and its providers, Vanessa Hamalian, APRN and / or Sonya Merritt APRN and/or any other Health Care Providers employed by Latitude Clinic LC, (together "Practice") and "Beneficiary", who is (or becomes) a beneficiary enrolled in Medicare Part B (together with his/her legal representative or legal guardian, if applicable, "Beneficiary") effective ("Effective Date").

Practice has informed Beneficiary that Practice has chosen to terminate its relationship with Medicare, effective 12-13-2021, and is not excluded from Medicare program under Sections 1128, 1156, 1892 and any other applicable sections of the Social Security Act.

The Beneficiary, or his/her legal representative or legal guardian, represents, warrants, agrees to, and expressly acknowledges the following:

1. Beneficiary or his/her legal representative or legal guardian accepts full responsibility for payment of Practice's charge for all services furnished by Practice.
2. Beneficiary or his/her legal representative or legal guardian understands that Medicare limits do not apply to what Practice may charge for items or services furnished by Practice.
3. Beneficiary or his/her legal representative or legal guardian agrees not to submit a claim to Medicare or to ask Practice to submit a claim to Medicare.
4. Beneficiary or his/her legal representative or legal guardian understands that Medicare payments will not be made for any items or services furnished by Practice that would have otherwise been covered by Practice if there was no private contract and a proper Medicare claim had been submitted.
5. Beneficiary or his or her legal representative understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
6. Beneficiary or his/her legal representative or legal guardian enters into this Private Contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not terminated or opted-out of Medicare, and Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not terminated or opted-out.
7. Beneficiary or his/her legal representative or legal guardian understands that Medi Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
8. Beneficiary or his/her legal representative or legal guardian acknowledges that Beneficiary is not currently in an emergency or urgent health care situation.
9. Beneficiary or his/her legal representative or legal guardian acknowledges that a copy of this Private Contract has been made available to him or her before any items or services were furnished to Beneficiary by Practice.

Sign here to indicate that you have read and agree to the "Private Contract"

Signature _____ Date _____

Office Policies and Procedures

WHEREAS, Latitude Clinic ("Practice") provides primary care medical services and delivers personalized care; and WHEREAS, Patient, desires to contract with Practice to obtain such services and care. NOW, THEREFORE, Patient agrees to abide by the following business policies:

1. Initial Consult Time Limitations. Prior to the Initial Consult, Patient must fill out the medical history questionnaire and consent form
2. Appointment Cancellation Policy. If for any reason Patient must cancel a scheduled visit, patient shall give Practice written notice at least twenty-four (24) hours before the appointment time. Cancelations with less that 24 hours of notice and No-Shows will be charged a cancelation fee of $50 for a Basic Visit and $100 for an Extended Visit.
3. Payment for Services Provided. Payment is expected at time of service or prior to time of service. We do not offer terms or payment plans. Delinquent payments will result in discharge from the practice. We accept cash, card and personal check.

Bounced checks will incur a $50 charge.

4. Regarding Care During Hospitalization and Emergencies. Practice medical providers, including Vanessa Hamalian APRN and/or Sonya Merritt APRN and/or any other Health Care Providers employed by Latitude Clinic LLC, do not admit patients to the hospital or treat hospitalized patients. Hospitalized patients are managed by the Hospitalists. Latitude Clinic requests that patient or family member notify us, Latitude Clinic, as quickly as possible upon admission and call for immediate out-patient follow up upon discharge.

If Patient encounters a medical emergency and is not able to obtain care from his or her primary care physician(s), Patient is advised to contact 911 or report to a hospital emergency department immediately.

5. Non-Participation in Insurance. Patient understands and acknowledges that Practice does NOT participate in any private or government funded health insurance, PPO or HMO plans or panels or Medicare or Medicaid. Patient shall not submit bills to Medicare or Medicaid for Services even if deemed to be a covered service under such insurance or health care plan. Patient acknowledges that neither Practice nor its professionals, including Vanessa Hamalian APRN and/or Sonya Merritt APRN, and/or any other Health Care Providers employed by Latitude Clinic LLC, will bill any third-party health insurance plan for the Services provided to patient.

However, Patient may, at Patient's discretion, independently submit bills only to Patient's private insurance company, (NOT MEDICARE or MEDICAID). However, Practice does not make any representation or warranty whatsoever that any fees paid under this Agreement are covered by Patient's health insurance plan. Patient shall be fully and completely responsible for payment to Practice. Patient is hereby advised to either obtain or keep in full force such health insurance policy(ies) or plan(s) that will cover Patient for general health care costs

6. Private Contract. If Patient is eligible for Medicare, then Patient agrees to sign a Private Contract in the form designated by Practice as of Jan 1, 2022. To the extent required by law, Patient agrees to enter into a renewed Private Contract every two (2) years, as requested by Practice.
7. Consult Communications Outside of Visit. Practice will not provide care in terms of portal messaging support, phone calls outside of the context of a visit.
8. General Communications Policy. Patient understands and agrees that e-mail communications (outside of the secure patient portal), facsimile, video chat, instant messaging, and cell phone are not guaranteed to be encrypted, secure or confidential methods of communications. Patient agrees that any communications made outside of the patient portal are made at Patient's risk with respect to all e-mail communications. Patient understands that use of electronic communication outside of the secure patient portal has inherent

limitations, including possible breach of privacy or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

Practice may not respond to e-mails or other messages that contain sensitive medical information. If a response is requested, Practice may respond through the secure patient portal. Though it is Practice's preference only to respond through the patient portal, by initiating correspondence through an unsecure and/or unencrypted channel, Patient hereby expressly waives Practice's obligation to guarantee confidentiality with respect to correspondence using such means of communication and Practice may respond in like kind if deemed appropriate by Provider. Patient understands and acknowledges that Practice may retain any communications between Practice and Patient and include such communications in Patient's medical record.

Patient understands and agrees that portal messaging or e-mail are not appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation that Patient reasonably believes could develop into an emergency, Patient shall call 911 or proceed to the nearest emergency room, and follow the directions of emergency personnel.

Practice checks telephone and portal messages during business hours and responds to them on a regular basis throughout the week. Portal messages are to be used for non-urgent messages only, and a response will generally be sent within two (2) business days. By leaving a telephone or portal message, Patient acknowledges and agrees that a prompt reply is NOT required or expected and acknowledges that Patient will not use portal messages to deal with emergencies or other time sensitive issues.

Practice expressly disclaims any liability associated with any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of any action, inaction, technical issues, or activity outside Practice's control, including but not limited to, (i) technical failures attributable to any Internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address portal messages, (iii) failure of Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third-party; or (v) Patient's failure to comply with the guidelines regarding use of e-mail communications set forth in this Section.

I acknowledge and certify that:

- I understand the above Consents, Office Policies and Procedures.
- I have had opportunities to ask questions and have had them answered to my satisfaction.
- I have read and fully understand the foregoing Consents, Office Policies and Procedures, and I have all of the knowledge I currently desire.
- I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

Sign here to indicate that you have read and agree to the "Office Policies and Procedures"

Signature _____ Date _____

Consent for Medical Treatment of a Minor

I am the parent or legal guardian of the minor that is being scheduled and I have the legal authority to give consent for the treatment of this minor and hereby authorize Family and Pediatric Autonomous Nurse Practitioners at Latitude Clinic and/or such assistants to provide such diagnostic or medical treatment to such minor as may be considered necessary or appropriate under the circumstances which may include, without limitation, arranging for and/or authorizing consultation, evaluation, referral, treatment, including medication administration, for the above named minor. I agree that treatment may be provided in my absence.

I understand that medical treatment is not without risks. The benefits and risks will be explained to me. I understand I should ask any questions I have prior to signing this consent.

Potential risks associated with the medical treatment include but are not limited to the risk of infection, bleeding, need for a secondary treatment, scar tissue formation and discomfort or pain at site.

I accept the treatment recommendation of my child's healthcare provider. I acknowledge that no warranty or guarantee has been made as to the results of any recommended treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my child's provider. I further certify that I will ask any questions I have before or after my child's provider has informed me of the nature and character of the proposed treatment, of the anticipated results of this treatment, of the possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

This consent shall remain in effect unless it is revoked in writing.

Sign here to indicate that you have read and agree to the "Consent for Medical Treatment of a Minor"

Signature _____ Date _____

Informed Consent

(Hereinafter "I") seek the medical services of Latitude Clinic ("Practice"). I am executing this informed consent document ("Informed Consent") to verify and confirm my discussion with Vanessa Hamalian APRN and/or Sonya Merritt APRN ("Provider") and/or any other Health Care Providers employed by Latitude Clinic LLC, regarding the risks, benefits, and alternatives to treatment through Practice. I am here for my own purposes and not on behalf of any third-party. I understand that I am a participant in the decision making process, and I am free to decline services or treatments at any time. I agree to bring to the attention of Practice's clinical staff, if, at any time, I have any lack of understanding of such risks, benefits, and alternatives, and inquire of clinical staff for further explanation until I have a full understanding before giving consent to any procedure or treatment.

1. Primary Care Pediatric and Family Scope of Practice

I understand that Provider and his/her team may use diagnostic and treatment methods that, in addition to conventional health care, may be known as preventative, complementary, or off- label. In general, the medical care provided may provide benefits that include relief of presenting symptoms and improved function that may lead to prevention, improvement, or elimination of the presenting symptoms, though no particular outcome can be warrantied or guaranteed.

2. Off-Label Use of Medications

In addition, I understand that Provider may at times use FDA-approved medications to treat a condition in a way that differs from the use specifically approved by the FDA for such medication. This is commonly known as "off-label use." Provider has informed me of this practice and will inform me and provide the opportunity for me to ask questions if Provider decides to use an FDA-approved medication off-label in conjunction with my treatment. I am requesting that Provider use his/her judgment in prescribing FDA approved medications for me that are off-label but which he/she believes to be appropriate.

3. Insurance and Financial Responsibility

I understand that Practice does not accept insurance and I agree that I am financially responsible for the services rendered. I understand that Practice may provide me with a receipt for services called a "superbill." I understand that I may submit this superbill to my commercial or private insurance company or third-party payor. I understand that I may not receive full reimbursement or any reimbursement at all from these third-party payors. I also understand that if I am, or during the course of my relationship with Practice, become an eligible Medicare Beneficiary, then I will NOT submit any request for reimbursement to Medicare and I will be given notice of Practice's status with respect to Medicare and that I will be given separate notice about my financial responsibilities as they relate to Medicare.

NOTE: Do not schedule an appointment unless you have read this form and all consents and feel that you understand all.

Call (941)253-253 to ask any questions you might have before scheduling an appointment.

By scheduling an appointment, I acknowledge and certify that I have had an opportunity to ask questions and have had them answered to my satisfaction; I have read and fully understand the foregoing Informed Consent, and I have all of the knowledge I currently desire; I have discussed the issues noted above with Provider, and I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

Sign here to indicate that you have read, have had the opportunity to ask questions and agree to the "Informed Consent"

Signature _____ Date _____

Latitude Clinic LLC

Disclosure of Medical Information Consent Form

Patient's First Name _____ Last Name _____Date of Birth _____

Address_____City _____ State_____Zip _____

I authorize the following disclosing party To disclose the following health information

_____ _____

The above party may disclose this health information to the following recipient:

Latitude Clinic LLC
2831 Ringling Blvd, Suite F220, Sarasota FL 34237
P: (941) 253-2530 F: (941) 303-8619 Email: (941) 303-8619

The purpose of this authorization is Authorization ends

___ At My Request for Continuity of Care Date_____

___ Other ____When Latitude Clinic is no longer providing my care

My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient Signature or Authorized Representative _____

If patient is a minor or unable to sign, please complete the following:

Name of Signing Authorized Representative Authority of representative to sign on behalf of the patient

_____. ___ Parent ___ Legal Guardian ___ Court Order

Latitude Clinic LLC

Disclosure of Medical Information Consent Form

Patient's First Name _____ Last Name _____Date of Birth _____

Address_____City _____ State_____Zip _____

I authorize the following disclosing party

Latitude Clinic LLC
2831 Ringling Blvd, Suite F220, Sarasota FL 34237
P: (941) 253-2530 F: (941) 303-8619
Email: ringling@latitudeclinic.com

To disclose the following health information:

Medical Records

The above party may disclose this health information to the following recipient:

_____

The purpose of this authorization is

___ At My Request for Continuity of Care

___ Other

Authorization ends

Date_____

____When Latitude Clinic is no longer providing my care

My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

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Patient Signature or Authorized Representative _____

If patient is a minor or unable to sign, please complete the following:

Name of Signing Authorized Representative

_____

Authority of representative to sign on behalf of the patient

___ Parent ___ Legal Guardian ___ Court Order