

Date _____
Fecha _____

Patient Registration Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - Información del Paciente

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre Segundo Nombre

Last Name _____
Apellido

Sex _____ Date of Birth _____ / _____ / _____
Sexo Fecha de Nacimiento

Marital Status Married Single Divorced Widowed
Estado Civil Casada Soltera Divorciada Viuda

Race/Ethnicity _____
Raza/Etnia

(Check One) Employed Retired Full-Time Student
Marque Uno Empleada Retirada Estudiante Tiempo Completo

Other _____
Otro

Employer _____
Empleador

Work Phone (_____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____
Telefono del Hogar Telefono Cellular

I was referred to: _____ by / por
Fui recomendado por

Friend _____ Relative _____
Amigo Familiar

Physician _____ Insurance _____
Médico Seguro

Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

Existing Patient of the LLC _____
Paciente Existente de la LLC

Other _____
Otro

Insurance Information - Información del Seguro

Please provide your insurance card to the receptionist - Por favor entregue su tarjeta de seguro a la recepcionista

Commercial Medicaid Medicare Worker's Compensation Other _____

Insurance company _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone (_____) _____
Numero de Poliza Numero de Grupo Telefono

Secondary Insurance Information - Información del Seguro Secundario

Commercial Medicaid Medicare Worker's Compensation Other _____

Insurance company _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone (_____) _____
Numero de Poliza Numero de Grupo Telefono

Emergency Contact - En Emergencias, contactar a:

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre Segundo Nombre

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Pharmacy - Farmacia

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

Spouse / Guarantor / Responsible Party - Esposo / Persona Responsable

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre Segundo Nombre

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

Sex _____ Date of Birth _____ / _____ / _____
Sexo Fecha de Nacimiento

Daytime Phone (_____) _____
Teléfono durante el día

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañía de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S.458.320 (5) (g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañía de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE

DATE

Patient Name: _____ Weight _____ Height _____

Reason for Visit (briefly): _____ Name of Primary Care Physician: _____

AS REQUESTED BY YOUR INSURANCE CARRIER, Please Select Gender Identity and Sexual Orientation

| | | | |
|-----|--|---|----------|
| F | Female | S | Straight |
| M | Male | G | Gay |
| FTM | Transgender Male / Female to Male | L | Lesbian |
| MTF | Transgender Female / Male to Female | B | Bisexual |
| G | Genderqueer: Neither Exclusively Male nor Female | O | Other |
| D | Declined | U | Unknown |
| O | Other | D | Declined |

List your current medications:

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |
| | | |

Please circle if you have any of the following:

High Blood Pressure Diabetes Asthma Fibromyalgia Liver Disease

Do you have any illnesses not listed above? _____

Any allergies to medications? If so, list _____

GYN History

| | |
|--------------------------------------|---------------------------------------|
| Total Number of Pregnancies = | When did you become menopausal? |
| Number of Living Children = | Are you sexually active? |
| Number of Abortions = | What is your method of contraception? |
| When was your last menstrual period? | |

| | | |
|---------------------------|---------------------------------|-----------------------------------|
| Date of Last PAP Smear | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Date of Last Mammogram | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Date of Last Bone Density | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Date of Last Colonoscopy | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

| | | |
|-----------------------|--|--------------------------------------|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many cigarettes per day? |
| Do you drink alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many drinks per day? |
| Do you use drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please list |

List all surgeries you have had in your lifetime (including cosmetic surgery): _____

Family History – List medical illnesses (Hypertension, Diabetes, Cancer (Cervical; Uterine; Ovarian, Breast etc)

| | |
|----------------|--|
| Mother | |
| Father | |
| Aunt/Uncle | |
| Sister/Brother | |

Review of Systems – Please circle if you CURRENTLY have any of the following:

- | | | | | | |
|------------------|----------------|---------------------|------------------|---------------------|-----------------------|
| Fever | Joint Pain | Seizure | Excessive Thirst | Vomiting | Anxiety |
| Chills | Joint Swelling | Numbness/Tingling | Too Hot/Too Cold | Diarrhea | Depression |
| Weight Gain | Infection | Headache | Tired/Sluggish | Anemia | Suicidal Thoughts |
| Nipple Discharge | Hay Fever | Blood in Urine | Asthma | Swollen Glands | |
| Skin Rash | Drug Allergy | Pain upon Urination | Cough | Blood Clotting | |
| Blurred Vision | Ear Infection | Heavy Menstruation | Short of Breath | Chest Pain | None |
| Double Vision | Sore Throat | Vaginal Discharge | Abdominal Pain | High Blood Pressure | |
| Vision Loss | Sinus Problem | Pain During Sex | Nausea | Palpitation | (Patient Intake Form) |

1447 Medical Park Blvd., Suite 401
Wellington, FL 33414

Office 561-798-4100
Fax 561-798-4351

Isaac Halfon, M.D., F.A.C.O.G.



Obstetrics & Gynecology

CONSENT TO RECEIVE MESSAGES

Do we have permission to leave medical information (i.e., test results) on your home/cell voice mail or answering machine?

_____ Yes _____ No

Do we have permission to text you your medical information (i.e., test results)?

_____ Yes _____ No

Patient Printed Name

Date

Patient Signature

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Authorization to Release Information

Many of our patients allow family members, such as their spouse, significant other, parents or children to call and request results of test, procedures and financial information. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family member, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the office of Isaac Halfon, M.D., to release my records and any information to the following individuals,

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____
5. _____ Relation to Patient: _____

Patient Name (Print)

Patient Signature

____/____/20____
Today's Date

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

There will be a \$50.00 charge or 5% of the check amount, whichever is greater, added to your account balance for checks returned unpaid by your bank. In addition, interest will be accrued for balances over 30 days at 25% per annum and a 50% collection fee added to account balances over 90 days. We reserve the right to make adjustment to these fees at any time.

Charges may also be assessed to your account for missed appointments and appointments cancelled without 24-hours advance notice.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. If, for any reason, your insurance denies services, medication or medical devices, you will be directly responsible for payment.
3. Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
4. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. Any medication or services provided that are not covered by your insurance is the responsibility of the patient and you will be balance billed accordingly.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the Office Manager promptly for assistance in the management of your account.

For our HMO patients: Your insurance carrier requires you to have a referral for every visit to Dr. Halfon. (Some do allow one well woman check up per year without a referral.) IT IS YOUR RESPONSIBILITY TO OBTAIN YOUR REFERRAL PRIOR TO YOUR VISIT WITH DR. HALFON. IF YOU DO NOT HAVE YOUR REFERRAL, YOUR VISIT WILL HAVE TO BE RESCHEDULED (DELAYING YOUR TREATMENT AND CARE.)

Cancellations require advanced notification otherwise a fee will be charged to your account (see no show policy form). Refunds may be subject to a processing fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Name: _____ Signature: _____ Date: ____/____/20____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Isaac Halfon MD FACOG 1447 Medical Park Blvd, Suite 401, Wellington, FL 33414

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- ◆ A photocopy of this assignment shall be considered as effective and valid as the original.
- ◆ I authorize Isaac Halfon M.D., to deposit checks received on my account.
- ◆ I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- ◆ I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ◆ I authorize Dr. Halfon to bill me directly if, for any reason, my insurance carrier fails to pay any portion of the claim.

If appointments are NOT cancelled in advance, a charge will be applied to your account (see no show policy form).

Dated at Wellington, FL on _____/_____/20_____

Signature of Policyholder

Signature of Claimant if other than Policyholder

PATIENT REFUND PREFERENCE & AUTHORIZATION FORM

| |
|--|
| Patient Name: |
| Patient DOB: |
| Practice Name: Office of Dr. Isaac Halfon |
| Physician/Provider Name: Isaac Halfon, M.D. |

PURPOSE

Patient overpayments will be returned within 30 days once the overpayment is determined and validated. Before a refund can be issued, any outstanding balance on your account (or on the account of your covered dependents) must be paid first. This ensures that all charges are accurate and fully resolved.

This form allows you to tell us in advance how you would like us to handle any overpayment after all outstanding balances have been addressed. You can update your preference at any time by completing a new form and submitting it to the Practice.

REFUND PREFERENCE (select one)

Option #1: Refund Any Overpayment to Me

I prefer to receive a refund for any confirmed overpayment after all outstanding balances for myself and my dependents have been paid. Refunds will be issued to the original payment method (credit card, electronic payment, or check).

Patient Initials: _____

Option #2: Leave Credit on My Account for Future Services

I authorize the Practice to keep any confirmed overpayment as a credit on my account after all outstanding balances for myself and my dependents have been paid. This credit may be used for future services for myself or my dependents unless I later request a refund.

Patient Initials: _____

ACKNOWLEDGEMENT & AUTHORIZATION

I knowingly and voluntarily authorize the Practice to handle any confirmed patient overpayment in accordance with the option that I selected above. I understand this authorization is provided for my convenience and may be relied on by the Practice unless and until I change or revoke by completing a new form. I acknowledge and affirm that I have had the opportunity to ask questions regarding this form and my refund options.

| |
|---------------------------|
| Patient Signature: |
| Patient Name: |
| Date: |

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Obstetrics & Gynecology

LABORATORY CONSENT FORM

During your visit it may be deemed advisable by Dr. Halfon to collect specimens (pap smear, biopsy, culture, blood work, etc.) in order to adequately diagnose and treat you.

Your signature below (patient and/or guardian) gives permission to The Office of Isaac Halfon, M.D. to collect such specimens and send them to laboratory for analysis. Please make sure at the end of your visit that you understand which specimens are being submitted to the lab on your behalf (pap smear, STD testing, bloodwork, etc.)

You may receive a bill from the laboratory. You are expected to know your insurance's preferred laboratory and to provide this information to the medical assistant at your visit.

You understand that the Office of Isaac Halfon, M.D. and the laboratory corporations (including, but not limited to, LabCorp, Quest, Invitae, Medipath, Myriad Genetics etc.) are separate entities and therefore bill separately for services rendered.

The Office of Isaac Halfon, M.D. will not be held financially responsible for services billed by the laboratories.

You are recommended to contact your insurance provider, and/or the laboratory directly if questions or concerns arise regarding billing of lab specimens.

Patient Name: _____

Patient Signature: _____

Date: _____

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Obstetrics & Gynecology

NO SHOW POLICY

Dear Patient,

We understand you may sometimes need to reschedule appointments. When we make your appointment, please understand we are reserving time for you to see a provider.

This courtesy makes it possible to give you the best service possible.

- Should you need to reschedule your appointment, please call our office as soon as possible or at very least 24 hours in advance.

If you just fail to show for your scheduled appointment, you will be charged at the following rates:

- \$ 25.00 No Show for an Office Visit
- \$ 50.00 No Show for an Ultrasound Visit
- \$100.00 No Show for a Pelvic Floor Therapy Visit
- \$200.00 No Show for an Office Procedure

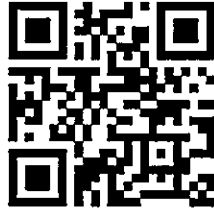
All that is needed to avoid a no-show fee is to contact our office a minimum of 24-hours in advance.

We thank you for your trust in choosing our office for your medical needs.

Print Patient Name / Date

Signature of Patient

NOTICE OF PRIVACY PRACTICES



<https://www.toplinemd.com/practice-terms-policies/>

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice’s Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature: _____

Patient or Legal Guardian Name (print): _____

Date: _____

Office Use Only

We have made the following attempt to obtain the patient’s signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

MALPRACTICE INSURANCE NOTICE

Dear Patients,

By law, all physicians practicing in the state of Florida must notify their patients if they do NOT carry malpractice insurance. The malpractice insurance for Obstetricians and Gynecologist is not affordable and difficult to obtain. For this reason, myself and most other Obstetricians and Gynecologist in this state, have chosen NOT to carry malpractice insurance. I will provide you with the highest quality of medical care. Thank you for choosing our office for your medical needs.

Below is a copy of the official state statute S.458.320(5)(g)5 posted in the office:

“Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law”

Thank you.

Isaac Halfon, M.D., F.A.C.O.G.

I, _____ (print name), have read and understood the above Malpractice Insurance notice.

_____ (please sign your name and date)

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Isaac Halfon, M.D., F.A.C.O.G.



Obstetrics & Gynecology

NEW STATE LAW EFFECTIVE JULY 1, 2020

Gov. DeSantis recently signed into law a requirement that women must consent, in writing, to a pelvic examination prior to being examined.

Therefore, beginning on July 1st 2020, we will be asking all patients to sign a consent for a pelvic examination every time they have an exam or procedure.

We apologize for any inconvenience, but this is a requirement of the law in the State of Florida and we must abide by this new legislation.

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

- (X) A female Gynecological Exam which may include a rectal exam and/or a pelvic exam
- (X) Other procedures as listed _____
- (X) Examination of external genitalia
- (X) An Ultrasound Exam which may include a probe placed in the vagina
- (X) Pelvic Floor Therapy which may include a probe placed in the vagina and/or rectum

This examination will be performed by any provider in the office of Isaac Halfon, M.D., LLC.

The consent will remain active until I withdraw my consent in writing.

Print Patient Name or Patient's Representative if under 18

Signature of Patient or Patient's Representative if under 18

Date _____

E-mail Consent & Acknowledgment Form

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication.

These include, but not limited to, the following risks:

- a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
- b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
- c. E-mail senders can easily type in the wrong email address.
- d. E-mail is easier to falsify handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
- g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into the computer system.
- i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
- b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

- a. Limit or avoid using his/her employer's computer.
- b. Inform Provider of changes in his/her e-mail address.
- c. Confirm that he/she has received and read the e-mail from the Provider.
- d. Put the patient's name in the body of the e-mail.
- e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
- f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- g. Withdraw consent only by e-mail or written communication to Provider.

E-mail Consent & Acknowledgment Form

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : _____

Patient Signature : _____

Date : _____

Patient Email: _____

Telehealth informed consent form

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "Telehealth Informed Consent" informs the patient ("patient," "you," or "your") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services provided:

Telehealth services offered by Isaac Halfon, M.D, LLC, and the Practice's engaged providers (our "Providers" or your "Provider") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "Services"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling
- Completion of medical intake forms
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider
- Two-way interactive audio-video interaction between you and your Provider
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files
- Delivery of a consultation report; and/or other electronic transmissions for the purpose of rendering clinical care to you

Expected benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Please call our office directly to schedule your telehealth appointment.
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling our office directly at 561-798-4100.



TopLine MD
Alliance

- More efficient care evaluation and management. You may request a telemedicine appointment and should receive a response within 24 hours. We will try our best to schedule your appointment by the end of the requested date.

Service limitations:

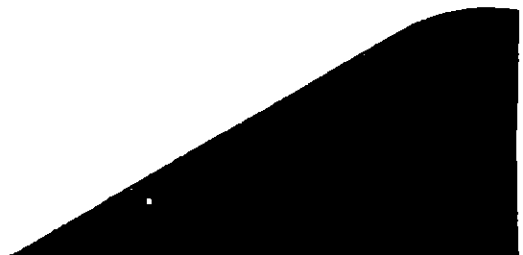
- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT DR. HALFON, M.D., LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 561-798-4100.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.



Patient acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.
2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.
5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.
8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
9. I understand I have the right to object to the videotaping of the telehealth consultation.
10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.
11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.
13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.



- 14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.
- 15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
- 16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:



ACCEPT. By checking the Box for this "TELEHEALTH INFORMED CONSENT" I hereby state that I have read, understood, and agree to the terms of this document.

Patient's name

Parent/Legal guardian's name

Patient's signature

Parent/Legal guardian's name

Date

Date

