QuickStop Health

Patient Intake Packet

Practice Policies & Procedures

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Thank you for choosing QuickStop Health ("Practice," "we," or "us") for your primary care and women's health needs! Jasy Yin, a California licensed nurse practitioner, owns QuickStop Health, which provides high-quality women's health services, primary care, and other specialties ("Services"). Please contact us if you have questions about your treatment options and eligibility for any Services.

We require all of our patients to review and agree to these policies and procedures prior to beginning or continuing Services. Please take the time you need to read this document and raise any questions you may have prior to checking the box or signing the document below. We may update these policies and procedures at our discretion and will provide you with a copy of any updated policies upon request.

By signing or checking the box, you acknowledge and agreed to be bound by these updates.

If material changes to any policies occur, we will request that you complete a new set of intake forms.

If you experience a medical emergency, immediately call 911.

Communication Policies

- **Communications**. By providing us with the information on this document or by initiating communications with Practice by unsecured email or text message, you authorize us to call, leave voicemails, and respond to your text messages. We will only contact you for non-marketing purposes, including appointment reminders, billing and invoicing updates, and treatment questions.
- **Use of Unencrypted Methods of Communication**. You also understand that communicating with us by unencrypted emails may be unsecured. This also means that any of your protected health information that is transmitted in this way, including information about your appointments, diagnosis, progress, and other individually

identifiable information, may be unsecured. If you choose to communicate with us via email, please limit the content to general information (such as scheduling or asking for a time to talk via phone). Please be aware of privacy risks when using electronic means of communication.

- **Hours of Operation**. Practice is not on call at all hours. We return messages within 48 hours of receipt, excluding weekends and holidays. If you are in an emergency situation, contact 911, visit your nearest emergency facility, or contact the National Suicide Prevention Lifeline, which offers a free 24-hour hotline by dialing 988.

Practice Payment Information

- **Payment**. All fees for Services rendered are due at the time of service. You understand that you are wholly responsible and liable for payment of all charges and fees assessed for Services rendered. Practice does not accept insurance of any kind. Please contact us if you have any questions about our payment policies. The Practice is out-of-network with all insurers, and we ask that you pay the Practice at the time of service. Should you choose to submit claims on your own for out-of-network reimbursement, your insurance may not cover these Services, or it may consider them to be subject to lower out-of-network benefits. We do not guarantee that your insurance will cover Services. Your insurance company will also not pay some fees, like cancellation fees, and these fees will be solely your responsibility to pay.
- **Good Faith Estimate**. You are entitled to receive a Good Faith Estimate of the expected charges for our Services. Practice will provide you with a Good Faith Estimate before your scheduled Services and can produce copies upon request.
- **Cancellations**. To respect our time and yours, please be available at your appointment time. Practice requires at least 24 hours' notice prior to canceling an appointment. If you fail to cancel an appointment more than 24 hours before the appointment time, you will be charged a $50 cancellation fee.

- We require all patients to provide payment information and keep payment information on file with Practice. Practice accepts health savings account cards, flexible spending account cards, debit cards, and credit cards. By providing your card information, you authorize us to charge unpaid balances and fees of any kind

to the card, including late cancellation and no-show fees. We will save this credit card information in your file for future charges.

Social Media, Substance Abuse, Recording, and Conduct Policies

- **Social Media Policy**. Our providers will not accept friend or contact requests from current or former patients on any social networking site. Adding patients or contacts of patients on social networking sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our professional relationship. However, if we develop a patient-facing public page for social media purposes, feel free to add that page.
- **Substance Abuse**. We will not provide you with Services if you are under the influence of recreational drugs or alcohol during our sessions or if we strongly suspect that you are under the influence of recreational drugs or alcohol and we believe engaging in Services is detrimental to your well-being. If you come to a session under the influence of recreational drugs or alcohol, or we come to you and determine that we cannot provide Services to you, you will remain responsible for the payment of any billed charges.
- **Recording**. The Practice prohibits anyone from recording or taking photographs throughout the provision of any Services.
- **Expected Conduct**. If you engage in aggressive behavior or communication toward your Practice provider or engage in dangerous behavior (to be determined at the sole discretion of the Practice provider), We will immediately conclude our Services, and you will remain responsible for the payment of any billed charges. We may also take other action as necessary, including but not limited to involving law enforcement.

Privacy, Security, and Health Records

- **Notice of Privacy Practices**. We comply with all state and federal medical privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). These laws require us to protect the privacy and security of your health records and personal information. We have implemented privacy policies and procedures to ensure Practice's compliance with these requirements. This

information is summarized in our Notice of Privacy Practices. Please let us know if you have questions about how we protect your privacy.

- **Records**. We maintain records about your treatment. If you want a copy of your records, or if you want us to send your records to another provider, please ask us for a copy of your records. Please note that, in some instances, we may charge reasonable and cost-based copying, postage, scanning, or digital storage device fees.

Mandatory Reporting

- **Child Abuse**. California law requires us to report all child abuse to local law enforcement or Child Protective Services ("CPS"). We must call CPS if we have reasonable cause to believe that a child who is known to us in our professional Capacity may be abused or neglected. It is Practice's policy to notify you prior to contacting CPS if, in its professional judgment, it is reasonable to do so.
- **Elder Abuse**. California law also requires us to report the abuse of elders or vulnerable adults to local law enforcement or the Adult Protective Services ("APS") office in the relevant county if we reasonably suspect abuse. This may include physical, sexual, financial, or psychological abuse, neglect, or exploitation.
- **Duty to Protect**. If you tell Practice or any of its providers that you intend to cause serious harm to a specifically identifiable victim, including yourself, and we determine that you present a clear and imminent risk of harm, we may take steps to protect the potential victim by making reasonable efforts to communicate the threat to the victim and law enforcement. This means that we may disclose otherwise confidential information for this purpose.

Notice to Patients

- Nurse practitioners are licensed and regulated by the Board of Registered Nursing.

- To check up on a license or to file a complaint go to www.rn.ca.gov, you may also email the Board of Registered Nursing at enforcement.BRN@dca.ca.gov, or call (916) 322-3350.

Discontinuing Care

- At any time during your receipt of Services, you, your designee, or your other healthcare providers can choose to discontinue care. In cases where Practice terminates your receipt of Services, it may provide appropriate referrals to other treatment providers or facilities as necessary.
- Practice also reserves the right to discontinue care if Practice, or any of its providers, determines that existing conditions affecting your health and well being require a higher level of care. In the event Practice determines it must discontinue care, it will refer you to another provider that Practice reasonably believes is capable of addressing your treatment needs.

Overview of Telehealth Services

- **Method of Treatment**. We may provide telehealth services to you electronically, using audio-visual communications and information technologies, including real-time interactive services, as may be clinically appropriate.
- **Scope, Standards, and Professional Ethics**. We utilize evidence-based telehealth practice guidelines and standards of practice to the degree they are available to ensure your safety, quality of care, and positive outcomes. Services provided through telehealth must satisfy the same standards of care and professional ethics as healthcare providers who use traditional in-person treatments with patients. We utilize our best efforts to ensure that any services provided are consistent with our scope of practice, including education, training, experience, ability, licensure, and certification.
- **Our Relationship**. When the standard of care does not require an in-person encounter, following evidence-based standards of practice and telehealth practice guidelines that address telehealth's clinical and technological aspects, we may establish a provider-patient relationship through telehealth alone.
- **Rights, Risks, and Benefits**. You have the right to withdraw your consent to receive telehealth at any time without affecting your right to future care or treatment. You understand that there are risks and consequences of receiving services through electronic modalities, including:
    - *Information Disrupted*. The transmission of your personal information could be disrupted or distorted by technical failures.

- *Information Interrupted*. The transmission of your personal information could be interrupted by unauthorized persons.
- *Information Lost*. The electronic storage of your personal information could be unintentionally lost or accessed by unauthorized persons.
- *Inadequate Information*. Telehealth technology may not provide adequate information during the visit. If this occurs, we will inform you before the conclusion of the live telehealth interaction.

Considerations for Telehealth

- **General Considerations.** Please log in and show up to your telehealth appointment at least five minutes before the actual appointment time to make sure that your audio and video are operating properly. You are fully responsible for making sure that you are in a safe, quiet environment that offers you sufficient privacy and a good-quality internet connection.
- **Safety.** To ensure your safety, the safety of others, and your full ability to participate in the appointment, Practice will not provide telehealth services to you while you are driving.
- **Guests**. If you bring someone into the space where you are receiving telehealth Services, you are consenting to their presence in your treatment while you receive Services from the Practice. You understand that their presence may compromise the privacy and confidentiality of our conversations, the provision of services, and any scheduled treatment.
- **Telehealth Technology and Equipment**. We utilize technology and equipment that complies with all relevant laws, regulations, and codes for technology and technical safety for devices that interact with patients. All technology used by the Practice is compliant with HIPAA and has been determined to be sufficient in quality, size, resolution, and clarity, so we believe we can effectively provide telehealth services to you. Although we use specific technology platforms to provide Services, we have no other affiliation with our platform(s) of choice.

Disclosure and Functionality of Telehealth Services

Before we proceed with any services via telehealth, we will disclose, through direct communication, our telehealth terms and conditions of use, our privacy policy, our HIPAA Notice of Privacy Practices, this document, and the following:

- the specific services we will provide and limitations on such services;
- the costs and fees;
- any financial interests, other than fees charged, in any information, products, or Services we provide;
- appropriate uses for and limitations of telehealth technologies, including in emergencies;
- to whom we will disclose your patient health information, as defined by HIPAA;
- your right to privacy related to your patient health information, as defined by HIPAA; and
- information collected and passive tracking mechanisms utilized.

Plan in Case of Technology Failure

Telehealth technology is not always reliable. Consequently, the most reliable backup is a phone. We recommend that you always have a phone available and that you provide us with your phone number so that we can contact you in the event of a technological failure. If you get disconnected from a video conferencing or chat session, please end and restart the session. If you are unable to reconnect within ten minutes, we will call you during our scheduled appointment time. If you are on a phone session and your phone disconnects, we will attempt to call you back.

Telehealth Informed Consent

Before we can provide Services to you, the law requires that we obtain your informed consent. Informed consent may be obtained only after discussing the Services we will provide to you and the potential risks, benefits, and alternatives to such Services. Therefore, you acknowledge and agree that we will render initial clinical evaluation Services via telehealth, as we have discussed. You will also sign documents that describe the material risks, benefits, and alternatives of receiving Services.

I, the undersigned patient, understand that by checking the box provided, I acknowledge that I have read and agreed to the terms outlined in the document. I further acknowledge and agreed that this action will serve as my electronic signature and consent.

- **Agreement to this Document**. I have read and understand this entire document and the Practice's Policies and Procedures, and I agree to be bound by every part. I agree to update the Practice with any changes to my health. I have received the Practice's Notice of Privacy Practices.
- **Additional Agreements**. I agree that I will receive a copy of my Practice Provider's contact information, including their name, telephone number, voice mail number, business address, and email address (if applicable). I also understand that I must read and sign the Practice's intake paperwork before I receive care.
- **Agreement to Receive Telehealth Services, if Appropriate**. I agree and understand that my Practice provider will determine whether receiving Services via telehealth is appropriate for my case in the provider's professional judgment. If my provider decides that telehealth services are appropriate for my case, I consent to receive telehealth services.
- **Telehealth Platform**. I agree to be bound by the Practice's telehealth platform's terms and conditions of use.
- **Recording**. Neither party has consented to the recording of appointments, and I agree that I will not record any appointments.
- **Payment Authorization**. If I have provided the Practice a payment method through the telehealth platform or otherwise, I hereby authorize such payment method to be charged for appointments to receive Services consistent with the Practice's fee schedule then in effect and for other purchases or Services, cancellations, and other fees. I agree that my payment method will be saved to the Practice's files.

The preceding information has been discussed in a way that I, the undersigned patient, understand. The Practice has informed me below of the risks and benefits of, and alternatives to, receiving Services.

I understand how to contact my Practice provider should additional questions arise. I agree and acknowledge that (i) Services may not have the results that I expect or desire, and (ii) I have not been given any guarantees about the outcome of Services.

I have been offered ample opportunity to discuss my concerns about the Services before my first appointment, and all questions have been answered to my satisfaction.

I, the undersigned patient, understand that by checking the box provided, I acknowledge that I have read and agreed to the terms outlined in the document. I further acknowledge and agreed that this action will serve as my electronic signature and consent.

Informed Consent for Services

Patient name | **Date of Services visit**

You will complete this form at your appointment.

Before Practice may provide Services to you, the law requires that we obtain your informed consent. You can only provide us with your informed consent after we have discussed your proposed Services, the potential risks of those Services, the potential benefits of those services, and information about any possible alternative Services. Please tell us immediately if you experience any health changes or ever become uncomfortable during your receipt of Services.

In providing Services to you, we rely on your representations regarding: (i) your current medications, supplements, and vitamins; (ii) your medical history; (iii) your medical condition(s); (iv) your allergies; and (v) any suspected medical issues or conditions. You must provide these to us in advance of receiving Services. You are responsible for knowing and disclosing your individual health circumstances and conditions, including the medications, supplements, or vitamins you take, any allergies, your medical history and conditions, and any other restrictions related to your individual health.

Potential Benefits of Services

Receiving Services may lead to the identification and treatment of health conditions that may otherwise go undetected or untreated, many of which can lead to serious complications. It may also alleviate pain, discomfort, and other symptoms associated with such health conditions to improve your overall quality of life. Services may fully treat or address your particular health issue. Our experience gives our patients access to a wide array of services capable of addressing the most challenging patient needs. Such benefits may also require effort and diligence on the patient's part, depending on the treatment performed and the type of care that such treatment entails. We offer guidance to educate

our patients and make them more comfortable seeking healthcare services for concerns particular to women but also primary care and other specialties.

Potential Risks and Side Effects of Services

Receiving Services may also involve some risks, including discomfort, infections, disturbances in your menstrual cycle, pain (in your stomach, pelvis, or other area of treatment), cramps, vaginal bleeding or discharge, bruising, spotting, pain or discomfort during sex, and allergic reactions to medicines or drugs used in the treatment. In addition, you may experience reduced effectiveness of treatment due to the severity of your existing condition or the need for multiple appointments to treat the condition properly – both of which can be frustrating and require patience.

Alternatives to Services

Services are voluntary. You may elect or not receive treatment or services from Practice. An alternative is to obtain treatment with another healthcare provider. You may stop treatment at any time.

Patient Agreements and Acknowledgements

I, the undersigned patient, acknowledge that Practice, its owners, agents, employees, or independent contractors will provide Services to me.

I acknowledge that the ideas, goals, and treatment methods have been explained to me and that Practice will use appropriate treatment methods tailored to my individual circumstances as part of my treatment.

I further acknowledge that:

- The treatment and its benefits, risks, side effects, and alternatives have been explained to me;
- The treatment may not have the result that I expect, and I have been informed as to other possible treatments that may provide me a benefit;
- I will update Practice if, at any point, I experience changes in my health status that would change my eligibility for Services;
- I have not been given any guarantees about the result of any treatment;

- I will receive a copy of my provider's contact information, including their name, telephone number, voice mail number, business address, and email address (if applicable);
- I will be given a scheduled amount of time and opportunity to discuss my concerns, and all my questions will be answered during that time.
- I understand that Practice has the right to refuse services based on my provider's clinical or professional judgment and that even if I start Services, Practice has the sole right, based on my provider's clinical or professional judgment, to stop at any time;
- I agree to indemnify Practice against any and all claims, liabilities, losses, damages, suits, costs, and expenses, including reasonable attorney's fees, relating to my receipt of Services provided by Practice;
- I understand, acknowledge, and agree that my name and medical information may be disclosed to my emergency contact in the event of an emergency;
- I have read and understand this entire document and am bound by this document;
- I have truthfully provided the information requested in this document;
- I fully understand that I can withdraw this consent at any time to stop receiving Services;
- I have been offered and accepted Practice's Notice of Privacy Practices; and
- I authorize the use of my health information for these services.

I acknowledge that I am competent, understand this policy, and understand that I will be given material information regarding the proposed care, treatment, service, intervention, or procedure, and the anticipated benefits, risks, side effects, and alternatives, I will be given a scheduled amount of time and opportunity to discuss my concerns, and all my questions will be answered during that time.

Thus, I hereby provide my informed consent to receive the treatment as described in this document.

I, the undersigned patient, understand that by checking the box provided, I acknowledge that I have read and agreed to the terms outlined in the document. I further acknowledge and agreed that this action will serve as my electronic signature and consent.

_____

Patient Name

_____ _____

Signature **Date**