Merritt Health & Wellness

Registration

1. MY INFORMATION

Last Name (on your government-issued ID)

First Name and Middle Initial (on your government-issued ID)

You prefer to be called:

Birthdate: mm/dd/yyyy

What is your Social Security Number? (This is an encrypted platform and we require SSNs for treatment)

Cell Phone (555) 222-4444

Email Address

Mailing Address, City, State, Zip

Sex (Assigned at Birth)

○ Male ○ Female

How would you describe your gender identity?

○ Male ○ Female ○ Trans Male ○ Trans Female ○ Gender Non-conforming ○ Nonbionary ○ Other

How would you describe your pronouns?

○ He/Him ○ She/Her ○ They/Them ○ Other

How would you describe your relationship status?

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner

How tall are you?

How much do you weigh?

Which of the following best describes you? (The selection options for race and ethnicity have been updated according to the OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity that are included as part 2015 Edition EHR Certification.)

○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino
○ Native Hawaiian or Pacific Islander ○ White ○ Other

What is your preferred language?

How would you describe your ethnicity? You may opt not to answer.

Do you have a preferred local or mail order pharmacy?

○ Local ○ Mail Order

What is the name and address of your preferred pharmacy?

What is your Occupation?

2. MY INSURANCE INFORMATION

Name of your primary insurance carrier?

○ Aetna ○ Anthem BlueCross BlueShield ○ BlueCross BlueShield Federal Employee Program ○ CareOregon ○ Cigna
○ First Choice Health ○ Health Net ○ HMA ○ Moda ○ Pacific Source ○ Premera BlueCross BlueShield
○ Providence Health Plan ○ Providence Preferred ○ Regence BlueCross BlueShield ○ Regence Group Administrators
○ UMR ○ United Healthcare
○ If your insurance is not listed above, please do not proceed. Email ryan@merritthw.com to find out before continuing.

Name of the policy holder as it appears on the insurance card?

Policy holder's date of birth?

Subscriber ID number (not the group number)?

Group number (not the subscriber ID number)?

Do you have secondary insurance coverage?

○ Yes ○ No

If so, which carrier?

Name of the secondary insurance policy holder as it appears on the insurance card?

Secondary insurance policy holder's date of birth?

Secondary insurance subscriber ID number (not the group number)?

Secondary insurance group number (not the subscriber ID number)?

Print your full name and sign:

X

Ip Address

3. IN CASE OF EMERGENCY

Contact:

Phone # (333) 222-4444

Relation to Patient:

Medical History

4. MY MEDICAL HISTORY

What is the reason for your visit?

What is the name and contact information of the provider who referred you, or how did you hear about us?

Have you ever had an allergic reaction to any of the following medications?

☐ Codeine ☐ Morphine ☐ Penicillin ☐ Sulfa ☐ NONE/ NO Known Allergies ☐ Other

If you HAVE had a drug allergic reaction, what was your symptom/reaction?

Please type in any prescription medications you are currently taking. Please include the dosage and how often you take it per day. If you are not taking any medication please type 'None'.

Are you currently taking ANY VITAMINS OR SUPPLEMENTS? Please include the dosage and how often you take it per day. If you are not taking any medication please type 'None'.

Which vaccinations have you received?

☐ COVID ☐ Hepatitis A x 2 ☐ Hepatitis B x 3 ☐ HPV (Gardasil) ☐ IPV (Polio) x 3 ☐ Measles, Mumps, Rubella
☐ Meningitis (Menactra) ☐ TDAP (tetanus, diphtheria and pertussis) in the last 10 yrs ☐ NONE ☐ Other

Have you had any of the following conditions, or been hospitalized for any of the following conditions?

☐ Cancer ☐ Cholesterol Disorder ☐ Clotting Disorder ☐ Depression ☐ Diabetes ☐ Eye Disorder ☐ Heart Disorder
☐ High Blood Pressure - Hypertension ☐ Liver Disorder ☐ Lung Disorder ☐ Neurologic Disorder
☐ Orthopedic Disorder ☐ Skin Disorder ☐ Stomach/Intestinal Disorder ☐ Thyroid Disorder
☐ Urinary/Kidney Disorder ☐ NONE ☐ Other

Has anyone in your "immediate family" had any of the following conditions, or been hospitalized or had surgery for any of the following conditions?

☐ Blood Pressure Disorder ☐ Cancer ☐ Cholesterol Disorder ☐ Clotting Disorder ☐ Diabetes ☐ Eye Disorder
☐ Heart Disorder ☐ Liver Disorder ☐ Lung Disorder ☐ Neurologic Disorder ☐ Orthopedic Disorder
☐ Psychiatric Disorder ☐ Skin Disorder ☐ Stomach/Intestinal Disorder ☐ Thyroid Disorder ☐ Urinary/Kidney Disorder
☐ NONE ☐ Other

Which relative(s) had this condition?

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent ☐ Other

Please list any past surgeries including a close approximation of month and year the surgery took place:

Have you had any of the following vaccines or tests in the past calendar year?

☐ Bone density ☐ Cardiac stress test ☐ Chickenpox/vaccine ☐ Colonoscopy ☐ Diphtheria tetanus shot
☐ Hepatitis B shot ☐ HPV vaccine ☐ Physical exam ☐ Pneumonia vaccine ☐ Shingles vaccine ☐ Travel vaccines
☐ NONE of these

What were the results?

OVER THE PAST 2 WEEKS, how often have you had little interest or pleasure in doing things?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you felt down, depressed, or hopeless?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you had trouble falling asleep, staying asleep, or sleeping too much?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you felt tired or had little energy?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you experienced poor appetite or overeating?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you felt bad about yourself, felt that you are a failure, or you have let yourself or your loved ones down?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you had trouble concentrating on such things as reading or watching TV?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you been bothered by moving or speaking so slowly that other people noticed? Or, perhaps the opposite - being more fidgety or restless than usual?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

OVER THE PAST 2 WEEKS, how often have you had thoughts that you would be better off dead, or of harming yourself in some way?

○ 0. Not at all ○ 1. Several days ○ 2. More than half the days ○ 3. Nearly every day

The previous 9 questions were the Patient Health Questionnaire (PHQ-9), which is a screening tool for depression. Below is how the test is evaluated and scored.

PHQ-9 Score:

5-9 = Minimal Symptoms

10-14 = Minor or Mild Depression, Dysthymia

15-19 = Moderate Depression

>20 = Possible Severe Depression

If you are concerned about these answers please make sure to talk to your medical provider at your office visit.

What kind of diet do you maintain?

☐ Diabetic ☐ Gluten-Free ☐ No Dairy ☐ Pescaterian ☐ Regular ☐ Vegan ☐ Vegetarian ☐ Other

What do you usually eat for each meal and what do you snack on in between?

Describe your current weekly exercise routine:

○ Less than 1 Day Per Week ○ 1-3 Days Per Week
○ More than 3 Days Per Week

How would you describe your relationship with your body? (check all that apply)

☐ I feel content with my body. ☐ I have a positive relationship with my body. ☐ I sometimes struggle with body image.
☐ I sometimes struggle with the way I feel in my body ☐ I often struggle with body image.
☐ I often struggle with the way I feel in my body ☐ Other

5. MY FERTILITY & SEXUAL HISTORY

How would you describe your sexual orientation?

○ Bisexual/Pansexual/Queer ○ Gay/Lesbian ○ Straight ○ Other
○ Unknown

How would you describe your relationship structure?

○ Monogamous ○ Polyamorous ○ Other

How many sexual partners have you had in the past year?

Do you have regular periods?

○ Yes ○ No

When was your last regular period?

How many pregnancies have you had?

What brand or form of contraception do you use, if any?

☐ Cervical cap ☐ Condoms ☐ Depo-Provera ☐ Diaphragm ☐ Implantable ☐ IUD ☐ Oral contraceptives
☐ Tubal ligation ☐ NONE ☐ Other

How many children do you have (living or adopted)?

Have you had any of the following related to pregnancy?

☐ Abortions ☐ Ectopic Pregnancies ☐ Full Term Cesarean ☐ Full Term Vaginal Births ☐ Gestational Diabetes
☐ Miscarriages ☐ Pre-Term Cesarean ☐ Pre-Term Vaginal Births ☐ Still Births

Have you ever experienced sexual, physical, or mental/emotional abuse by anyone?

○ Yes ○ No

If "Yes", what kind of abuse?

○ Physical ○ Sexual ○ Mental/Emotional ○ Other

If "Yes", have you received mental health support surrounding this?

○ Yes ○ No

If "No" to the previous question, may your provider give you mental health resources?

○ Yes ○ No

Would you like your provider to discuss this, and any associated concerns you might have, with you further?

○ Yes ○ No

6. MY SUBSTANCE USE

Do you currently smoke, or have you ever smoked cigarettes in the past?

○ Non-Smoker ○ Ex-Smoker
○ Current Everyday Smoker

How many years have you been smoking (or did you smoke if not currently)?

How many cigarettes do you smoke per day?

Do you currently use, or have you ever used, any other tobacco products (cigars, pipe or chewing tobacco)?

○ I Do Currently ○ I Have in the Past ○ Never

Are you currently, or have you ever been, exposed to second-hand smoke at home or work?

○ Yes ○ No

Do you drink alcohol?

○ Yes ○ No

On average, how many days a week do you drink alcohol?

On a typical drinking day, how many drinks do you have?

Have you ever felt you needed to cut down on your drinking?

○ Yes ○ No

Have people ever annoyed you by criticizing your drinking?

○ Yes ○ No

Have you ever felt guilty about drinking?

○ Yes ○ No

Have you ever felt you needed a drink first thing in the morning (eye opener) to steady your nerves, or to get rid of a hangover?

○ Yes ○ No

Have you ever used drugs other than those required for medical reasons?

○ Yes ○ No

What recreational drugs have you used in the past year? (check all that apply)

☐ Cannabis (marijuana, pot) ☐ Cocaine ☐ Hallucinogens (LSD, mushrooms) ☐ Inhalants (paint thinner, aerosol, glue)
☐ Methamphetamines (speed, crystal) ☐ Narcotics (heroin, oxycodone, methadone) ☐ Tranquilizers (valium) ☐ Other

7. MY SYMPTOMS REVIEW

In terms of your overall health, have you experienced any of the following symptoms in the last 6 months?

☐ Chills ☐ Fatigue ☐ Feeling Poorly ☐ Fever ☐ Weight Gain ☐ Weight Loss ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

Have you gained or lost any weight recently?

○ No ○ Yes, I have gained weight recently ○ Yes, I have lost weight recently

How much?

In terms of your eye health, have you experienced any of the following symptoms in the last 6 months?

☐ Changes in vision ☐ Discharge from eye ☐ Double vision ☐ Dry eyes ☐ Eye discomfort ☐ Eye itchiness
☐ Eye pain ☐ Impaired vision ☐ Poor night vision ☐ Red eyes ☐ Other ☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your ears/nose/throat (ENT) health, have you experienced any of the following symptoms in the last 6 months?

☐ Ear ache ☐ Hearing loss ☐ Hoarseness ☐ Nose bleeds ☐ Ringing or buzzing in ear ☐ Sore throat ☐ Other
☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your heart health, have you experienced any of the following symptoms in the last 6 months?

☐ Chest pain ☐ Difficulty breathing in position other than upright ☐ Difficulty breathing on exertion
☐ Irregular heart beats ☐ Leg swelling ☐ Shortness of breath while lying down ☐ Other ☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your lung health, have you experienced any of the following symptoms in the last 6 months?

☐ Awakening short of breath ☐ Cough ☐ Difficulty breathing lying down ☐ Difficulty breathing on exertion
☐ Shortness of breath ☐ Spitting up blood ☐ Wheezing ☐ Other ☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your breast health, have you experienced any of the following symptoms in the last 6 months?

☐ Lumps ☐ Nipple discharge ☐ Skin Changes ☐ Swelling ☐ Tenderness ☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your stomach and intestine health, have you experienced any of the following symptoms in the last 6 months?

☐ Abdominal pain ☐ Black stool ☐ Blood in stool ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea
☐ Heartburn ☐ Painful swallowing ☐ Vomiting ☐ Other ☐ NONE

What is the approximate date when you began experiencing this symptom?

In terms of your urinary tract health, have you experienced any of the following symptoms in the last 6 months?

☐ Incontinence ☐ Painful period ☐ Painful urination ☐ Pelvic pain ☐ Vaginal discharge ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

In terms of your urinary tract health, have you experienced any of the following symptoms in the last 6 months?

☐ Genital lesion ☐ Hesitancy ☐ Incontinence ☐ Night urination ☐ Painful urination ☐ Testicular pain ☐ Other
☐ NONE

What was the approximate date when you began having this symptom?

In terms of your joint and muscle health, have you experienced any of the following symptoms in the last 6 months?

☐ Generalized joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Limb pain ☐ Limb swelling
☐ Specific joint pain from arthritis ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

In terms of your skin health, have you experienced any of the following symptoms in the last 6 months?

☐ Breast lump ☐ Breast pain ☐ Change in a mole ☐ Dry skin ☐ Itching ☐ Skin lesions ☐ Skin wound
☐ Unusual growth ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

In terms of your mental health, have you experienced any of the following symptoms in the last 6 months?

☐ Anxiety ☐ Change in personality ☐ Depression ☐ Emotional problems ☐ Sleep disturbances ☐ Suicidal thoughts
☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

In terms of your neurological health, have you experienced any of the following symptoms in the last 6 months?

☐ Confused ☐ Convulsions ☐ Difficulty walking ☐ Dizziness ☐ Fainting ☐ Limb weakness ☐ Other ☐ NONE

What was the approximate date when you began having these symptoms?

In terms of your endocrine health, have you experienced any of the following symptoms in the last 6 months?

☐ Deepening of the voice ☐ Erectile dysfunction ☐ Feelings of weakness ☐ Hot flashes ☐ Muscle weakness
☐ Protruding eye ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

In terms of your blood or lymphatic health, have you experienced any of the following symptoms in the last 6 months?

☐ Easy bleeding ☐ Easy bruising ☐ Swollen glands ☐ Swollen glands in the neck ☐ Other ☐ NONE

What was the approximate date when you began having this symptom?

Do you have any of the following symptoms related to sleep apnea and sleep disturbance?

☐ Diagnosed with Sleep Apnea ☐ High Blood Pressure or on blood pressure meds
☐ Neck circumference greater than 16" (women), 17" (men) ☐ Overweight ☐ Over 50 yrs old
☐ Stop Breathing, choke, gasp during sleep ☐ Tired, Sleepy, fatigued during the day ☐ Other ☐ NONE

Do you have any additional questions or concerns that you would like to discuss with your doctor today?

CLINIC POLICIES & DISCLOSURES

8. CONDITIONS OF TREATMENT

Consent to Treatment: The undersigned herby consents to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my provider, may be considered necessary or advisable. I understand that treatment may consist of, but is not limited to, telemedicine services (videoconference, telephone) in addition to in-person visits. I give my consent to Merritt Health & Wellness, LLC to audio record, video record, or photograph any interaction as deemed necessary for providing quality healthcare. I understand that these recordings, in part or in whole, may become part of my medical record and

may be used for internal purposes, such as quality improvement or education. I understand that telemedicine has its limitations and it does not substitute for the need to see a healthcare provider in person to sufficiently address my health concerns. I further understand that with whomever I establish care as my PCP, written instructions will be provided to me, my family, or my caregiver on whom to contact to follow up or obtain services.

Release of Information: The clinic will obtain my consent through written authorization to release information, other than basic information, concerning me, except in those circumstances when the clinic is permitted or required to by law release information. I certify that my records may be released to other providers upon request. By signing below, I agree that to the extent necessary to determine liability or payment, and to obtain reimbursement, the clinic may disclose portions of my record, including my medical records to any person or corporation which is or may be liable, for allor any portion of the clinic's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. Special permission is necessary to release this information where I may be treated for alcohol or drug abuse.

Medicare Alignment: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits: In the event I am entitled to insurance benefits arising out of any policy insuring me or any party liable to me, I hereby assign said benefits directly to this clinic for application to my bill. I agree that the clinic may issue a receipt for such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for all charges not covered by this agreement.

Financial Agreement: I hereby agree that I am financially responsible in consideration of services rendered by the clinic, and I shall make prompt payments to the clinic as bills are presented. I accept personal responsibility for all copayment, coinsurance, deductible, and non-covered service amounts as dictated by my, or the patient's, insurance plan. I agree to pay all fees and interest, at the legal rate, should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney or collection agency for collection. I acknowledge that should my account be turned over to an attorney or collection agency for collection, I forfeit my eligibility to continue as a patient of Merritt Health & Wellness, LLC.

I agree to the aforementioned conditions of treatment and understand that I will be required to sign one time, and this will be kept as part of my permanent file.

Do you agree with our Conditions of Treatment? You will need to answer YES in order to continue as a patient.

- ○ Yes

9. REGARDING INSURANCE COVERAGE FOR YOUR CARE

To help you understand insurance billing policies please read the following. Knowing these issues up front can save you time, hassle, finances and phone calls. In addition, it allows us to focus on your medical care. Our aim is for your total office experience to be as effective and pleasant as possible.

You will be responsible for visits or procedures that your insurance company denies as "not covered" or "excluded".

We will strive always to do our best to help you but cannot re-bill charges with changed diagnosis codes just to get your insurance to cover. This may be considered fraudulent by insurers and subjects the clinic to audits. Your presenting complaint becomes important in determining whether you are seen and billed correctly. We know many patients are frustrated by the cost of care, but we have no influence over the insurance regulations, their coverage of you and your family, and the payments required for co-pays and deductibles.

We accept most insurance plans (complete list is located on the FAQ page of our website) and as a courtesy we will file your insurance claim for you. However, since there are hundreds of different types of insurance plans, we cannot bend individual charges for each different plan, patient, or visit. We encourage you to familiarize yourself with your own plan prior to scheduling your office visit with us.

This includes what services are covered, what prior authorizations or pre certifications are needed, your deductible, and whether your insurance company will pay for such things as lab work and imaging studies. If your insurance company does not pay as expected, **please call their customer service department directly** as we are unable to guarantee your insurance benefits. We do not handle motor vehicle accident (MVA) claims, even for existing patients.

We request payment for office services at the time of your visit. We accept cash, checks, and most major credit cards and we can bill your health insurance plan for you if you provide us with a copy of your insurance card. Please inform us of any changes to your contact information or insurance coverage. Even if we have been seeing you for a while, we will need to see a copy of your insurance card at every visit. Small details in insurance coverage change from time to time and cards expire...we prefer to get things billed correctly for you the first time.

Bills that are unpaid may be charged a monthly finance charge.

Do you agree with the Insurance Coverage information? You will need to answer YES in order to continue as a patient.

- ○ Yes

10. POLICY STATEMENT: Payments

You will be required to provide proof of insurance at every visit. In compliance with new Federal Law, we will ask you for photo identification and may take your picture at your first office visit.

It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.

Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.

As with any provider's office, any charges you incur at Merritt Health and Wellness, LLC that are not paid or adjusted by your insurance carrier, will be YOUR sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.

If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.

We accept cash, checks, and credit/debit card payments. There is a $50 fee for returned checks in addition to any fees charged by your financial institution.

Payment is due within 30 days of receiving your bill. If your outstanding balance is not paid in full within six (6) months, your account will be sent to collections and you will be charged any additional cost of the collections process on top of the balance you owe. Additionally, you will be discharged from our clinic.

Merritt Health and Wellness, LLC will continue providing care for you while you pay off this balance provided all office visits and other clinic charges acquired from this day forward are paid in full at the time of service.

Do you agree to/understand our Payments Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

11. POLICY STATEMENT: Prescription Refills

Please allow 3 to 5 business days for all prescription refills. Ask your pharmacy to fax a refill request to the clinic at (866) 309-2838 to expedite the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

Do you agree to/understand our Prescription Refills Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

12. POLICY STATEMENT: Records

We are happy to provide you a copy of your medical records gratis with a signed release of information (ROI) form. However, additional copies will require a charge in accordance with OAR 847-012-000.

Do you agree to/understand our Records Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

13. POLICY STATEMENT: Changes in Demographic/Insurance Information

It is your responsibility to advise the clinic of any change in insurance coverage, or changes in name, address, or telephone number.

Do you agree to/understand our Changes in Demographic/Insurance Information Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

14. POLICY STATEMENT: 24-Hour Cancellation/Missed Appointments

Our clinic requires a 24-hour cancellation notice for all appointments because your appointment time is reserved for you. **If you do not show up or give the clinic less than 24-hour notice, you will receive a $50 late cancellation/missed appointment fee. If you violate this policy three (3) times, you may be dismissed as a patient.**

If you cannot make it to your scheduled appointment, please call (971) 258-1120 to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who may need to be seen on that day, and in turn, helps us find time for you when you need to be seen on short notice.

Unlike most other clinics that double-book office visits, we do not double-book our appointments and reserve office visits 30 to 60 minutes in length. Therefore a 24-hour cancellation notice from you is vital to providing the longer appointments our patients require for comprehensive health care. **There will be a $50 charge for a missed appointment or less than 24-hour cancellation notice.** This charge will not be paid by your insurance company.

Do you agree to/understand our 24-Hour Cancellation/Missed Appointments Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

15. POLICY STATEMENT: After Hours Urgent Services (On-Call Providers)

We provide 24/7 on-call coverage. If you have an urgent matter that can't wait until business hours, you may reach an on-call provider by calling the clinic and following the prompts on the outgoing message.

However, you should be aware that many insurance companies provide 24-hour nursing lines intended for this purpose and therefore may not cover this service.

This service is not intended for non-urgent matters, scheduling appointments, or prescription refill requests.

Do you agree to/understand our After Hours Urgent Services (On-Call Providers) Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

16. POLICY STATEMENT: Motor Vehicle & Worker's Compensation Claims

We **DO NOT** see patients for motor vehicle accidents (MVA's) or worker's compensation claims, even existing patients who are already established.

Do you agree to/understand our Motor Vehicle & Worker's Compensation Claims Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

17. POLICY STATEMENT: Specialty Referrals

Many private insurances allow patients to self-refer to specialists. We are happy to make recommendations for you.

We work hard to maintain relationships with specialists. When you fail to show up for a referred appointment we have made for you, it reflects poorly on us and jeopardizes our ability to refer patients to these specialists in the future.

Therefore, similar to our 24-hour cancellation/missed appointment policy, if you repeatedly fail to show to a referred appointment, you will be dismissed from the practice.

Do you agree to/understand our Specialty Referrals Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

18. POLICY STATEMENT: Attending to Children

We know that it can be difficult to find childcare and we love kids, however the clinic is full of dangerous items and children should not be present during procedures for the sake of everyone's safety.

Please monitor your children at all times while at the clinic. We will not monitor your children during your office visit.

Do you agree to/understand our Attending to Children Policy? You will need to answer YES in order to continue as a patient.

- ○ Yes

19. POLICY STATEMENT: Privacy Policy

NOTICE OF PRIVACY PRACTICES

Effective Date: February 16, 2026
Merritt Health & Wellness, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Merritt Health & Wellness, LLC (“we,” “us,” or “our”) is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

We are required by law to:

Maintain the privacy and security of your protected health information (“PHI”)
Provide you with this Notice of our legal duties and privacy practices
Notify you following a breach of unsecured PHI
Abide by the terms of this Notice currently in effect
Not use or disclose your PHI other than as described here unless you authorize us to do so

Protected Health Information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

1. Treatment

We may use and disclose your PHI to provide, coordinate, or manage your health care and related services.

Examples include:

Consultation with other providers
Referrals to specialists
Care coordination activities

2. Payment

We may use and disclose your PHI to obtain payment for services provided.

Examples include:

Billing and collections
Claims management
Determining eligibility or coverage
Utilization review
Medical necessity determinations

3. Health Care Operations

We may use and disclose your PHI for operational purposes, including:

Quality assessment and improvement
Reviewing provider qualifications
Legal and auditing services
Business planning and development
Customer service and administrative activities
Limited fundraising communications (you may opt out)

4. Required by Law

We may disclose PHI when required by federal, state, or local law.

5. Public Health and Safety

We may disclose PHI for:

Public health activities
Reporting abuse, neglect, or domestic violence
Health oversight activities
Preventing or lessening a serious threat to health or safety

6. Judicial and Law Enforcement Purposes

We may disclose PHI in response to:

Court orders
Subpoenas
Law enforcement requests meeting HIPAA requirements

7. Research

We may use or disclose PHI for research purposes under strict federal requirements.

8. Specialized Government Functions

Including:

Military and veterans' activities
National security
Correctional institutions
Workers' compensation

SPECIAL PROTECTIONS FOR REPRODUCTIVE HEALTH CARE INFORMATION

In accordance with federal law, we will not use or disclose PHI related to reproductive health care for purposes of:

Conducting criminal, civil, or administrative investigations
Imposing liability
Identifying individuals for investigation or prosecution

if the reproductive health care was lawfully provided.

When required by law, we may obtain a signed attestation that the requested use or disclosure is not for a prohibited purpose before releasing reproductive health information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

We will not use or disclose your PHI without your written authorization for:

Psychotherapy notes (with limited exceptions)
Marketing communications (where required by law)
Sale of PHI
Substance Use Disorder (SUD) treatment records
Any other use not described in this Notice

You may revoke your authorization at any time in writing, except to the extent we have already acted on it.

YOUR RIGHTS

1. Right to Access and Obtain Copies

You have the right to inspect and obtain a copy of your PHI in your designated record set.

You may request electronic copies if maintained electronically.
We will provide access within 30 days (with one 30-day extension if necessary).
We must provide PHI in the requested form and format if readily producible.
Reasonable, cost-based fees may apply.

We may deny access in limited circumstances as permitted by law and will provide written notice of denial.

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2. Right to Amend

You may request amendment of your PHI if you believe it is incorrect or incomplete.
We may deny requests under certain conditions but will provide a written explanation and your appeal rights.

Requests should be submitted in writing to:

Seth Merritt, FNP
Merritt Health & Wellness, LLC

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3. Right to Request Restrictions

You may request restrictions on uses or disclosures of your PHI.

We are not required to agree to most restrictions.

However, we must agree to a restriction if:

The disclosure is to a health plan,
The disclosure is for payment or health care operations, and
The PHI pertains solely to services for which you have paid out-of-pocket in full.

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4. Right to Confidential Communications

You may request that we communicate with you:

At an alternative address
By alternative means (e.g., phone, email, mail)

We will accommodate reasonable requests.

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5. Right to an Accounting of Disclosures

You may request a list of certain disclosures made during the six (6) years prior to your request.

The first accounting in a 12-month period is free. Reasonable fees may apply for additional requests.

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6. Right to Breach Notification

You have the right to be notified following a breach of your unsecured PHI in accordance with federal law.

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7. Right to a Paper Copy

You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Seth Merritt, FNP
Merritt Health & Wellness, LLC

You may also file a complaint with:

U.S. Department of Health & Human Services
Office for Civil Rights (OCR)
https://www.hhs.gov/ocr/privacy/hipaa/complaints/

Complaints must generally be filed within 180 days of when you knew or should have known of the violation.

You will not be retaliated against for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. Changes will apply to all PHI we maintain. The updated Notice will be:

Posted at our office
Posted on our website: www.merritthw.com
Available upon request

Do you agree to/understand our Privacy Policy? You will need to answer YES in order to continue as a patient.

○ Yes

20. POLICY STATEMENT: Email, Telehealth and HIPAA Information. What you need to know about e-communicating your information to medical providers.

Information contained in emails sent from MHW can be minimally secure even though we have obtained a Business Associate Agreement with Google which provides HIPAA compliance. For your own privacy, please do not email content you do not wish to be seen by other parties. Should you choose to communicate via email, be aware that all emails are retained in the logs of internet service providers on both sides of this communication. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by system administrators of the ISP's used.

EMAIL/TEXT CONSENT FORM Before sending email/text communications to MHW Healing Arts Center Providers ("MHW"), please read and agree to the following information regarding the risks and conditions of email/text use: RISKS ASSOCIATED WITH USING EMAIL/TEXT

MHW offers patients the opportunity to communicate by email/text. However, transmitting patient information by e-mail/text has a number of risks that should be considered. These include, and are not limited to, the following risks:

• Email/text can be circulated, forwarded, and stored in numerous paper and electronic files.

• Email/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.

• Email/text senders can easily misaddress an email/text.

• Email/text is easier to falsify than handwritten or signed documents.

• Backup copies of email/text may exist even after sender or recipients have deleted their copy.

• Employers and on-line services have a right to archive and inspect emails/texts transmitted through their systems.

• Email/text can be intercepted, altered, forwarded, or used without authorization or detection.

• Email/text can be used as evidence in court.

CONDITIONS FOR THE USE OF EMAIL/TEXT

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

• Although MHW will endeavor to read and respond properly to an email/text, MHW cannot guarantee that any particular email/text will be read and responded to within any particular period of time. Thus, no one shall use email for medical emergencies or other time sensitive matters. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.

• All emails/texts sent to providers must be sent to their respective email/text addresses.

• Providers will likewise respond to all patient emails/texts from their respective email/text address.

• All Emails/Text to or from MHW patients concerning diagnosis or treatment will be printed out and, at the Provider's discretion, may be made a part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as a staff or billing personnel, will have access to those emails/texts.

• MHW may forward emails/texts internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. MHW will not, however, forward emails/texts to independent third parties without the patient's prior written consent, except as authorized or required by law.

• If the individual's email/text required or invites a response from MHW, and the individual has not received a response in a timely manner or within a business week, it is the individual's MHW responsibility to follow up by telephone to determine whether the intended recipient received the email/text and when the recipient will respond.

• Individuals should not use email/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

• Individuals are responsible for informing MHW of any types of information that they desire not to be sent by email/text, in addition to those called out in the above paragraph.

• The individual is responsible for protecting his/her password or other means of access to email/text. MHW is not liable for breaches of confidentiality caused by the individual or any third party.

• MHW shall not engage in email/text communication that is unlawfully practicing medicine across state lines.

• It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

COMMUNICATION BY EMAIL/TEXT To communicate by email/text, patients shall:

• Limit or avoid the use of his/her employer's computer.

• Inform MHW of changes in his/her email/text address.

• Put the patient's name in the body of the email/text.

• Review the email/text to make sure it is clear and that all relevant information is provided before sending to MHW.

• Take precautions to preserve the confidentiality of email/text, such as using screen savers and safeguarding his/her computer password.

• Withdraw consent only by written communication to MHW.

ACKNOWLEDGEMENT & AGREEMENT

I understand and acknowledge that I have read and fully understood this consent form. I request and consent to MHW using email/text to communicate with me at the e-mail address(es)/telephone number(s) that I provide and I understand that such communications may contain my protected health information, including health history, diagnosis and treatment information and demographic information. I understand the risks associated with email/text communication between MHW and me, and consent to the conditions outlined above. In addition, I agree to the instructions for communication by email/text outlined here, as well as any other instructions that MHW may impose to email/text communications. I understand and acknowledge that I have the right to withdraw my consent in writing at any time and that this authorization shall remain in effect until I withdraw my consent. Furthermore, I understand that MHW may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

If you wish to have HIPAA compliant conversations with any medical provider at MHW then please use the Patient Fusion portal system.

https://www.patientfusion.com

Merritt Health and Wellness Telemedicine Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

I. CONSENT TO TREAT: I, the patient identified below or the parent or legal guardian of the patient identified below (the "Patient"), consent for the Patient to receive telemedicine services from Merritt Health and Wellness LLC ("MHW"), including any diagnostic procedures, treatments and/or tests, that the physician(s), nurse practitioner(s), mental health staff, or physician assistant(s) (each, a "Provider") determine to be necessary and advisable.

I understand that telehealth technology will be used to connect the Patient with a Provider, and that such consultations may be conducted by videoconferencing and/or by telephone conference. I consent and authorize MHW to audio record, video record, and/or photograph the consultation as necessary for providing quality healthcare services via telehealth technology, which, in some cases, may be facilitated with the assistance of a facilitator who is not affiliated with or employed by MHW. I understand that all or a portion of the recordings, videos or images may become part of the Patient's medical record and that such information may be used for internal purposes, such as quality improvement or education. I understand that if such information is used externally for the advancement of medical knowledge or educational purposes, then the Patient's identity will remain anonymous and that such uses will be governed by MHW' Notice of Privacy Practices.

I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations in order to sufficiently address my health concerns.

I also understand that, as with any healthcare service, there are risks and the risks associated with telehealth may include equipment failure, poor image resolution, and security issues.

I understand the above information and I consent to telemedicine consultation.

I understand that MHW offers real-time, remote, interactive telemedicine consultations to patients and, in some instances, may offer limited medical examinations through the use of a peripheral medical device ("PMD") which can remotely examine the Patient's vital signs and systems and transmit such information to the Provider for evaluation. I understand that in cases where a PMD is used, a school nurse or other facilitator may assist in the telemedicine consultation by conducting an examination using the PMD. The PMD is manufactured and distributed by an independent medical technology company which is not affiliated with MHW.

I understand that MHW has implemented security measures sufficient to protect the Patient's electronic health information. Electronic health information is stored in a secure data center in encrypted format to prevent unauthorized individuals from viewing or accessing such data. MHW also utilizes password and authentication protections as additional safeguards where appropriate.

In choosing to participate in a telemedicine consultation, I understand that the use of telemedicine technology for diagnosing or treating health conditions presents certain risks, including but not limited to the following, which may occur in rare instances:

Transmitted information may be distorted or insufficient to allow for appropriate medical decision making;
There may be unanticipated delays in diagnoses or treatments due to equipment or technology failures or deficiencies;
The Provider's lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other medical decision errors;
Records of services provided may be lost through technical failures; and
In rare cases, security protocols could fail, causing a breach of privacy of personal medical information.

I have been advised and understand all the potential risks, benefits and alternatives to telemedicine and choose to proceed with a telemedicine consultation. I hereby release and hold harmless MHW from any loss of data or information due to technical failures.

In the event of an adverse reaction to treatment or if there is a telemedicine equipment failure, I understand that I may choose to re-initiate telemedicine services through the MHW platform or seek treatment from the Patient's primary care provider, an urgent care facility, or emergency department as appropriate under the circumstances. I also understand that the Provider may terminate the consultation if he or she feels that telemedicine services are inappropriate under the circumstances and may direct the Patient to an emergency department, urgent care provider or specialist as appropriate. I understand that the Provider's responsibility to provide medical services will end upon termination of the telemedicine consultation. I understand that I have the right to terminate the consultation at any time, without affecting the Patient's right to future care or treatment.

I authorize MHW to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), other applicable law, and by MHW Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

Policies Relating to Telehealth Programs

I understand that some telemedicine consultations will be conducted with the assistance of a facilitator, who is not employed by or affiliated with MHW. In such instances, I voluntarily consent for the facilitator of the medical examination to receive protected health information ("PHI") in order to carry out the treatment of the Patient and to remain in the room, where necessary, to aid in the consultation. I agree that MHW will not be responsible for the medical care, services, and treatment delivered by facilitators, nurses, physicians, or healthcare providers not employed by MHW.

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's health information for purposes of treatment, payment and to facilitate MHW health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct MHW to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize MHW to release billing information to any healthcare provider involved in the Patient's care.

III. ASSIGNMENT: I hereby assign, transfer and set over to MHW sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that services provided by MHW may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of MHW as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me or the Patient money that is designated to pay for the services provided by MHW, I agree to immediately send the check or an amount equal to the amount received by the insurance plan to MHW. I understand that all bills are to be paid immediately upon receipt. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for the services, that I will be responsible for any reasonable attorney's fees and collection fees incurred by MHW in collecting payment, in addition to the amount of the bill.

V. AFFIRMATION: I affirm that I have read and fully understand this MHW – Telemedicine Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Do you agree to/understand the privacy and HIPAA issues that can arise when using email and telehealth services? You will need to answer YES in order to continue as a patient.

- ○ Yes

Thank you for answering all of these questions in order to provide better care for you. Copies of these policies and privacy statements can be found online at www.merritthw.com under "Forms".

Print your full name and sign:

X _____ Ip Address