Financial Policy and Agreement

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in our office. All patients must also complete the information and insurance form before seeing a provider. The content of this document may not be changed.

1. Patient Information/Proof of Insurance: At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of services rendered.

2. Non-Insured: Patients who have no insurance are required to pay 100% of services rendered at each visit. We accept all major credit cards.

3. Insurance: We participate in most insurance plans, including Medicaid. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.

4. Referrals: Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full.

5. Co-payments, Co-Insurance, and Deductibles: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance, and deductibles from patients can be considered fraud. Deductibles are due at the time of notification by your insurance company. Such notification may be a verbal notice at the time of insurance verification, an Explanation of Benefits from your insurance company or a statement from Rose Creek Pediatrics, LLC (RCP).

6. Non-Covered Services: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid.

7. Coverage & Changes: You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay. If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.

8. Claims Submission: Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

9. Non-Payment/Delinquent Accounts: Each patient is responsible for his or her own bill. If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full to halt collection activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and processing costs. Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

10. Late Arrivals: A patient who arrives after the appointment time is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 10 minutes late, the appointment may be rescheduled.

11. Patients will be held liable for any damage done to the office.

USUAL AND CUSTOMARY RATES
Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers, pharmacy including formulary and prescription history, and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

MEDICAID CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for

resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal law, Rose Creek Pediarics is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with your physician prior to performing the procedure.

I authorize Rose Creek Pediatrics to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. I verify that my credit card information, provided above, is accurate to the best of my knowledge. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee to up to 40% of the principle amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. If the credit card information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand that by signing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

Insurance

I agree to keep track of insurance plan limitations on number of visits allowed per benefit year and authorizations, i.e. the number of visits used relative to those authorized by the expiration date of authorizations. To allow time for submission and review of paperwork and to help avoid a break in services while records are reviewed; I will notify my provider (or the office) at least one month before the approved number of visits are used and/or one month prior to the authorization expiration date. I am aware that my insurance company may request information to establish medical necessity regarding my treatment from Rose Creek Pediatrics and I give my consent for the release of this information. If insurance claims are submitted to insurance and payment is not received within 45 days I agree to follow up with insurance regarding payment. Further, I understand that if my insurance company does not allow benefits or approve payment of claims for services, I am responsible for all incurred charges and I agree to pay the balance in full in a timely manner.

I have read, understood, and accept the terms of the above mentioned.

Uses and Disclosures of Protected Health Information

The Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Practice has obtained your authorization for the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally or by facsimile.

Treatment. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of

your health care with anesthesia providers, nurses, technicians, lab personnel, radiology personnel, other practice staff involved in your care or a third party for treatment purposes. For example, we may disclose your protected health information to a laboratory to order pre-operative tests or to a pharmacy to fill a prescription. We may also disclose protected health information to physicians who may be treating you or consulting with the practice with respect to your care. In some cases, we may also disclose your protected health information to people outside the practice who may be involved in your medical care while you are in the Practice or after you leave the Practice, such as other physicians, health care workers, family members, clergy or others we use to provide services that are part of your care.

Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another involved in your case for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the Practice and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Other uses and disclosures for health care operations may include:

- Care management
- Protocol Development
- Training, accreditation, certification, licensing, credentialing or other related activities
- Activities related to improving health care or reducing health care costs
- Underwriting and other insurance related activities
- Medical review and auditing
- Business planning and/or development
- Internal grievance resolution

Appointment Reminders. We may use or disclose your protected health information to contact you, a family member or friend involved in your health care or as authorized by you as a reminder that you have an appointment for treatment or medical care at our practice. We may also leave a message on your answering machine / voicemail system unless you tell us not to.

Treatment Alternatives. We may use or disclose your protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest for you.

Health Related Benefits and Services. We may use or disclose your protected health information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We may use or disclose your protected health information to contact you in an effort to raise money for the Practice and its operations. We may disclose health information to a foundation related to the Practice so that the foundation may contact you in raising money for the Practice. We only would release contact information, such as your name, address, phone number and the date you received treatment or services at the Practice. If you do not want the Practice to contact you for fundraising efforts, you must notify the Contact Person in writing.

Individuals Involved in Your Care or Payment of Your Care. We may use or disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone assisting you in the payment for your care. We may also tell your family of friends that you are in the practice at the time of your care, or that information may be communicated to an entity assisting in a disaster relief effort in order to communicate your condition status and location to your family. If you want any of this information restricted you must communicate that to us using the appropriate procedure, which can be explained to you by practice staff.

Research. Under certain circumstances, we mat use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery or the health and recovery of all patients who received one procedure to those who received another procedure for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with the patients' need for research, the project will have been approved this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for the patients with specific health needs, so long as the health information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Practice.

As Required by Law. We will disclose health information about you when required to do so by federal, state, or local law. This may include reporting of communicable diseases, wounds, abuse, disease/trauma registries, health oversight matters and other public policy requirements. We may be required to report this information without your permission.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital event such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defeats, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.

- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency (i.e. State Health Department) for activities including audits; civil, administrative, or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-order warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the practice has a suspicion that your health condition was the result of a criminal conduct.
- In an emergency to report a crime.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we my release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with your health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety of the correctional institution.

To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ eye or tissue donation purposes.

For Specified Government Function. In certain circumstances, federal regulations authorize the practice to use or disclose your protected health information to facilitate specified government functions relating to military and veteran's activities, national security and intelligence activities, protective services for the President or others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The practice may release your health information to comply with worker's compensation laws or similar programs.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that it is directly relevant to the provider's involvement with your care, we may disclose your protected health information as described.

Uses and Disclosures which you Authorize. Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance to the authorization.

Your Rights. Although your health record is the physical property of the healthcare practitioner of Practice that compiled it, the information belongs to you. You have the following rights regarding your health information:

Right to Inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as we maintain the protected health information. A "designed record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, of for use in, a civil, criminal, or administrative action or proceeding; and protected health information that ids subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the first page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

Right to Request amendments to your protection health information. If you feel the health information we have in your records is incorrect or incomplete, you may request an amendment of the information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. In addition, we may deny your request if you ask us to amend information that:

- Was not created by this Practice, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or prepared for our Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

Right to Request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purpose to treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purpose as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. For example, you could ask that (1) we not use or disclose information about a surgery you had or (2) that certain people not be told of certain information.

The Practice is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the practice does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

Rights to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

Right to Receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the Practice. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a practice directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that takes place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

Our Responsibilities. The practice is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to:

- Keep your health information private and only disclose it when required to do so by law;
- Explain our legal duties and privacy practices in connection with your health records;
- Obey the rules found in this notice;
- Inform you when we are unable to agree to a requested restriction that you have given us;

- Accommodate your reasonable request for an alternative means of delivery or destination when sending your health information.

We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the practice changes its Notice, we will provide a copy of the revised Notice to current patients by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints. You have the right to express complaints to the Practice and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the practice by contacting the Practice's Privacy Officer verbally or in writing, using the contact information provided on this Privacy Notice. We encourage you to express and concerns you may have regarding the privacy of your information.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT

Rose Creek Pediatrics, LLC

4121 W 13400 S

Unit B

Riverton, UT 84096

Attn: Privacy Officer

The Privacy Officer can be contacted by telephone at 801-446-0102.

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

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA)) requires that health care providers inform patients of their rights regarding how the provider may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Privacy Notice describes our privacy practices that relate to your protected health information. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Contact Person. The practice's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this practice you may submit a complaint to our Privacy Officer by sending it to:

Rose Creek Pediatrics, LLC

4121 W 13400 S

Unit B

Riverton, UT 84096

Attn: Privacy Officer

The Privacy Officer can be contacted by telephone at 801-446-0102.

Your Health Record and Protected Health Information. Each time you receive medical care from a physician, surgical center, hospital, or other healthcare provider, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a history of your illness, injury or symptoms, any test results, x-rays and laboratory work, the treatment provided to you and treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what controls you may exercise over the use of your healthcare information is described in this Privacy Notice.

Telehealth Treatment Consent

- I understand that telehealth services are completely voluntary and that I can withdraw this consent at any time.
- I agree not to make or allow audio or video recordings of any portion of the sessions.
- I understand that the laws that protect privacy and the confidentiality of patient information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
- I understand that telehealth is performed over a secure communication system.
- I agree that the physician and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that I or my physician may discontinue the telehealth appointments at any time if itis felt that the video technology is not adequate for the situation.
- I understand that if there is an emergency during a telehealth session, then my physician may call emergency services and/ or my emergency contact.
- I understand that if the video conferencing connection drops while I am in an appointment, I will have an additional phone line available to contact my physician, or I will make additional plans with my physician ahead of time for re-contact.

I hereby give my informed consent for the use of telehealth in my care.