Simplicity DIRECT CARE

Consent for Medical Treatment and Fee for Service Payment Agreement

1. I ____ (patient name) give permission for Simplicity Direct Care to give me medical treatment.

2. I understand that Simplicity Direct Care is, by design, a small primary care practice which operates with minimal staff with a goal of streamlining the delivery of high-quality primary care services. Physician Services at Simplicity Direct Care are billed at approximately $100 per 20 minutes and I am responsible for payment on the day services are rendered via cash, credit card, HSA card or ACH (transfer directly from bank account).

3. I understand that neither Dr. Dygert nor Simplicity Direct Care accept insurance payment for physician services (other than Medicare). However, I will have access to my chart note, invoice, receipt, and billing codes that I can submit to my insurance company for reimbursement. Simplicity Direct Care does not guarantee that services will be reimbursed by any particular insurance company.

4. Many high deductible health plans will reimburse patients for a set of preventive services prior to meeting the annual deductible. Lists of services generally covered can be found here (https://www.healthcare.gov/coverage/preventive-care-benefits/), but each policy is different and I understand that I am responsible for checking my own policy for a list of covered preventive services.

5. I understand that I may be able to use funds from my Health Savings Account (HSA) to pay for medical treatment received at Simplicity Direct Care in accordance with Internal Revenue Services rules as stated in Publication 502 (https://www.irs.gov/publications/p502#en_US_2022_publink1000179065). If I choose to switch to a monthly membership plan, I understand that HSA funds are not allowed to be used for membership fees at this time.

6. I understand that I can use my insurance for any diagnostic testing (external labs, x-rays, MRI's, etc) ordered outside of Simplicity Direct Care and the diagnostic testing center is responsible for billing and collection for their services.

7. I understand that Simplicity Direct Care may have to send portions of my medical record information to my insurance company, when requested, for insurance to approve medications and diagnostic tests.

8. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

9. I understand that, with rare exception, prescription refills are filled only at the time of an in person or telehealth visit. At the time of each visit, Dr. Dygert and I will decide on a reasonable follow-up interval which allows for safe monitoring of the medical issue for which prescription has been written.

10. I understand that the scope of care provided by Dr. Dygert is limited to those services that health care providers are licensed to provide set forth by the Washington Medical Commission as delineated in Chapter 18.71 RCW and Chapter 246-919 WAC. Dr. Dygert may refuse to provide any service that she believes is

outside the scope of her training or that provider believes, based on her professional training, to have risks to the patient that outweigh benefit.

11. I understand that Simplicity Direct Care is often only staffed by Dr. Dygert and I may be asked to reschedule an appointment in order to ensure the presence of a medical chaperone for physical examination of sensitive areas of the body (i.e. genital exam).

12. I understand that Simplicity Direct Care may discontinue providing medical care if, in the opinion of Simplicity Direct Care, in its sole and absolute discretion, the patient:
    - Fails to pay any Fees or Costs owed for services provided by Simplicity Direct Care, after more than 30 days from when the Fees or Costs were due or
    - Has committed an act that constitutes fraud or
    - Repeatedly fails to comply with the recommended treatment plan or
    - Is abusive and presents an emotional or physical danger to the staff or other patients of Simplicity Direct Care.

13. I understand that Simplicity Direct Care has multiple HIPAA compliant methods of communication available to provide the easiest access for patients to communicate with Dr. Dygert. Spruce Health and Elation Electronic Health Record/Passport are utilized for communications with Dr. Dygert and allow for smart phone messaging, eFax, email, telephone and video. I understand that messaging, texting, eFaxing and email are inappropriate means of communicating regarding emergencies or other time-sensitive information. In the event of an emergency, or a situation in which I reasonably believe could develop into an emergency, I will call 911 or proceed to the nearest emergency room and follow the directions of the emergency personnel.

14. I understand that the staff at Simplicity Direct Care checks telephone and portal messages during business hours and responds to them on a regular basis throughout the week. Portal messages from the Elation electronic health record "Passport" are to be used for non-urgent messages only and a response will generally be sent within 2 business days. By leaving a telephone or portal message, I acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I will not use portal messages to deal with emergencies or other time sensitive issues.

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

____________________________________ __________________

Patient Name Date

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Signature of Patient

Name of Legal Guardian or Surrogate Decision Maker
(for patients under 18 and any patient with a surrogate decision maker)

Signature of Legal Guardian or Surrogate Decision Maker
(when applicable)