FARGO CENTER FOR DERMATOLOGY
CONSENT TO TREATMENT AND PAYMENT AUTHORIZATION

I. Consent to Treatment. I understand that I have the right to be informed of the nature and purpose of all services provided to me by or on behalf of Fargo Center for Dermatology, as well as alternatives, risks, consequences, or possible complications of such services, and acknowledge that such information has been provided to me. I authorize and give my consent to Fargo Center for Dermatology's provision of those services that my practitioner and I agree are necessary and appropriate for the diagnosis and treatment of my identified health conditions or concerns. I understand and agree that no guarantee has been made as to the results of the care, treatment, and/or medications provided by or on behalf of Fargo Center for Dermatology to me.

II. Artificial Intelligence.

I hereby consent to the use of Artificial Intelligence (AI) scribe dictation technology in the documentation of my medical records at Fargo Center for Dermatology. The information below provides details about the use of AI technology, its purposes, and the security measures in place to protect my privacy.

a.) PURPOSE OF AI DICTATION: AI scribe dictation technology is utilized to convert spoken words into text format for the purpose of documenting medical information in an efficient and accurate manner. The AI system may be employed in the transcription of medical notes, reports, and other relevant documents.

b.) HOW AI DICTATION WORKS: During my medical appointments, any verbal information provided by me or my healthcare provider may be recorded using AI scribe dictation. The AI system processes and transcribes spoken words into text, contributing to the creation of my medical records. The AI scribe will not be used to make any decisions about your care. Your doctor will review all of the information in your medical record, including the AI-scribed notes, before making any decisions about your care.

c.) SECURITY MEASURES: The medical practice employs robust security measures to safeguard the confidentiality and integrity of the information processed through AI dictation. These measures include encryption, access controls, and regular security audits to prevent unauthorized access and protect against data breaches.

d.) PATIENT RIGHTS: Access to Information: I have the right to request access to my medical records and transcripts generated through AI dictation. Amendment of Information: I have the right to request corrections or amendments to any inaccuracies in my medical records.

e.) BENEFITS AND RISKS:
Benefits:
- Increased efficiency in medical record documentation.
- Enhanced accuracy in transcribing verbal information.

Risks:
- Possibility of errors in transcription.
- Potential limitations in recognizing certain accents or speech patterns.

III. **Notice of Privacy Practices.** Fargo Center for Dermatology's Notice of Privacy Practices explains how Fargo Center for Dermatology may use and disclose my health information. It also explains my rights regarding my health information. Fargo Center for Dermatology may revise its Notice of Privacy Practices at any time, and will provide me with a copy of the revised Notice of Privacy Practices upon request. Fargo Center for Dermatology's Notice of Privacy Practices is available at the clinic and on its website FARGODERM.COM. By signing below, I acknowledge that I have received Fargo Center for Dermatology's Notice of Privacy Practices.

IV. **Prior Authorizations and Referrals.** I know that some services require a prior authorization or referral. I understand and agree that it is my responsibility to obtain and provide to Fargo Center for Dermatology any such authorization or referral before I receive the authorized/referred services. I understand that I am financially responsible for service costs that my health insurance provider refuses to pay due to an authorization or referral-related concern.

V. **Payment.**

a. **Payment Responsibility; Collection Costs.** I agree to pay for all services furnished to me by or on behalf of Fargo Center for Dermatology, including, but not limited to, charges that are not paid in full by my health insurance provider, government program benefits or other third-party payor within 60 days of being billed by Fargo Center for Dermatology, except as prohibited by Fargo Center for Dermatology's contract with my health insurance provider or applicable law. All such payments shall be due upon receipt of an invoice from Fargo Center for Dermatology.

b. **Payment Authorization.** I authorize Fargo Center for Dermatology to directly bill my health insurance provider or other third-party payor for services provided to me by or on behalf of Fargo Center for Dermatology. Notwithstanding the foregoing, I acknowledge that Fargo Center for Dermatology is not obligated to submit claims to my health insurance provider or other third-party payors on my behalf unless required by law or its contract with a third-party payor. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Fargo Center for Dermatology for any services furnished to me by Fargo Center for Dermatology. I understand and agree that Fargo Center for Dermatology is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

c. **Medicare and Medicaid Assignment of Benefits.** If I am entitled to Medicare or Medicaid benefits, I agree to inform Fargo Center for Dermatology of such benefits in advance of receiving services from Fargo Center for Dermatology. I request that payment of authorized Medicare, Medicare Supplement Insurance (Medigap), or Medicaid benefits be made either to me or on my behalf to Fargo Center for Dermatology for services furnished to me by or on behalf of Fargo Center for Dermatology. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services, Medigap insurer, or state Medicaid agency, and their respective agents, any information needed to determine these benefits or the benefits payable for related services.

d. **Release of Information.** I authorize Fargo Center for Dermatology to furnish my medical records and other information related to health care services provided to me by or on behalf of Fargo Center for Dermatology as necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I specifically authorize Fargo Center for Dermatology to release such information for these purposes the following: Medicare, Medicaid, or other public health program; my health

insurance company or health management organization; other payors; payer network organizations in which my providers participate, and file contractors and third-party administrators of these parties.

e. **Financial Policy.** I acknowledge that I have received, reviewed, and fully understand Fargo Center for Dermatology's Financial Policy, which Fargo Center for Dermatology may update from time to time. A copy of this Policy is attached hereto as Attachment A. I agree to fully comply with this Policy, as updated from time to time.

VI. Consent to Receive Electronic Communications. I understand that Fargo Center for Dermatology and its business associates and affiliates sometimes call, text, or email their patients about their health care and related matters. These communications may include appointment confirmations, follow-up care reminders, pre-appointment instructions, patient satisfaction surveys, billing notifications and other financial-related notifications, and information about other benefits or services that may be of interest to me. Fargo Center for Dermatology and its business associates and affiliates sometimes use automated, artificial voice, and/or prerecorded messages when delivering these communications via voicemail, text message, and/or email. I consent to Fargo Center for Dermatology and its business associates and affiliates sending these communications to any home telephone number, cellular telephone number, or email address that I provide to Fargo Center for Dermatology. I understand that I may opt-out of receiving these communications at any time by contacting Fargo Center for Dermatology.

VII. Sending Images and Other Information to Fargo Center for Dermatology. There may be times when I want to send images or other information about my skin condition(s) to Fargo Center for Dermatology. I understand that Fargo Center for Dermatology strongly encourages me to send any such images and information via its secure medical record patient portal, which I can access at fargoderm.ema.md, and will answer any questions that I may have about navigating this portal. If I choose to send images or other information to Fargo Center for Dermatology via another means (for example, by using my personal email account), I understand and agree that Fargo Center for Dermatology cannot and does not guarantee the security and privacy of the images and information sent by me.

VIII. Cancellation/No-Show Policy and Fee. I understand and agree that I must provide at least 24 hours' notice to Fargo Center for Dermatology if I am unable to keep a scheduled appointment. If I fail to show up for a scheduled appointment and do not provide this notice, Fargo Center for Dermatology may charge me a cancellation fee of (a) $50.00, for all medical appointments; (b) $100 for all surgery appointments, and (c) the lesser of $250.00 or 50% of the aesthetic service cost, for all aesthetic service appointments. A-list members may use banked funds to pay no show/cancellation fees. I agree to pay this cancellation fee within 30 days of the missed appointment. I further agree that Fargo Center for Dermatology may refuse to provide additional services to me until I have paid any outstanding cancellation fee(s). All fees collected will be donated to charitable organizations. See our community involvement page on our website to see where we have recently donated.

IX. Authorization to Charge Credit Card on File. As a convenience to me, Fargo Center for Dermatology may offer to store my credit card information securely within the electronic medical record. If I elect to have Fargo Center for Dermatology store my credit card information, I authorize Fargo Center for Dermatology to charge this credit card for any amounts owed by me to Fargo Center for Dermatology, including co-payments, service charges, and cancellation fees. I may change or remove the credit card information stored

by Fargo Center for Dermatology at any time by contacting Fargo Center for Dermatology. All aesthetic services will be required to provide a credit card on file at time of booking.

Attachment A
Fargo Center for Dermatology Financial Policy

- Co-Payments. All co-payments are due at the time of service.

- Private Pay Services. All payments for private pay services are due at the time of service. For the purposes of this Financial Policy, "private pay services" are services that are not paid for, in whole or in part, by a private or public health insurance provider or are provided to a patient who fails to provide a copy of their health insurance card at the time of the service.

- Minor Patients and Dependent Adult Patients. The parent(s) and/or guardian(s) who consent to services provided to a minor or dependent adult by or on behalf of Fargo Center for Dermatology are financially responsible for all costs associated with such services. This

- Complying with Health Insurance Plan Requirements; Ensuring Full Payment to Fargo Center for Dermatology. It is the patient's responsibility to understand their health insurance plan(s), and comply with any requirements that may be imposed by that health insurance plan(s). If the patient's health insurance provider refuses to pay for a service(s) provided by or on behalf of Fargo Center for Dermatology because the patient did not comply with any such requirement, the patient shall be responsible for paying for such services.

- Account Balances. Fargo Center for Dermatology reviews all patient accounts with a credit balance every 60 days or upon the reasonable request of the patient or the patient's health insurance provider. Fargo Center for Dermatology refunds credit balances of $10.00 or more by mailing a check to the appropriate party, which may be the patient, the patient's health insurance provider, or the account guarantor. If a patient has a credit balance, has an appointment scheduled within the next 30 days, and is expected to incur additional charges at that appointment (e.g., co-payment, deductible, co-insurance payment), Fargo Center for Dermatology may apply the credit balance to amount(s) owned by patient for that appointment. Credit balances of less than $10.00 will remain on the patient account for one year and, if unused during that year, will be written off.

- Returned Check Fee. All returned checks will be assessed a $30.00 processing fee.

- Referral to Collection Agency. Patient accounts that remain unpaid for more than 120 days may be referred to a collection agency. The patient shall be responsible for all costs associated with this referral and other collection-related costs. Typically, when accounts are referred to a collection agency, the patient is assessed a fee of $50.00 or 30% of the outstanding balance, whichever is greater.

Fargo Center for Dermatology may update and revise this Financial Policy from time to time, to the extent permitted by applicable law. Patients may obtain a copy of the current Financial Policy, at any time, from Fargo Center for Dermatology.

By signing below, I acknowledge that I have received, carefully read, and fully understand and agree with this General Consent for Treatment and Payment Authorization, including all referenced documents and attachments (collectively, this "Consent"). I have had the opportunity to ask any questions that I may have about this Consent, and any such questions have been answered fully and to my satisfaction. I understand and agree that this Consent shall remain in effect until I notify Fargo Center for Dermatology, in writing, that I am revoking this Consent.

Patient's Name:_____ Date of Birth: _____

Name of Patient's Legal Guardian (if applicable): _____ Relationship to Patient: _____

Home Telephone Number: _____Okay to leave voicemail? Yes _____ No _____

Cellular Telephone Number: _____Okay to leave voicemail? Yes _____ No _____

Email Address: _____

Signature of Patient or Patient's Legal Guardian: _____

Date Signed: _____