Informed Consent for Treatment of a Minor:

We cannot legally treat a minor child without a signed consent form. You must be present at your child's initial visit to sign the parental consent form

Minor Information:

Patient Name:____ Patient DOB: ____________________

Parent/Legal Guardian Information:

Name: ____ SSN#: ___________________________

DOB: ____ Primary phone #: _____________________

Relationship to Patient: ________________________________ Secondary phone #: ___________________

If you are not the parent, you will need to provide legal documentation that you are the legal guardian. The information will be kept in the patient's file.

Special Permissions: this agreement is required in order for the minor child to be treated in person or via a secure telehealth platform without the parent/legal guardian present.

_______ (initials) **Unaccompanied:** I grant permission to treat and provide any healthcare services to the minor child that the provider deems necessary for treatment if my child arrives at the office or engages in a telehealth visit unaccompanied

_______ (initials) **Accompanied by others:** If I am unable to accompany the minor child to the appointment or be present during a telehealth visits, the below listed individuals have my permission to accompany my child or be present with them on a telehealth visit and make medical decisions regarding the child:

Other individuals Allowed to Accompany Minor:

Name: _________________________________ DOB: ___________ Relationship to Child: _____________

Name: _________________________________ DOB: ___________ Relationship to Child: _____________

Consent to treat Minor: I authorize Heartland Weight Loss to treat and provide any healthcare services to my child deemed necessary for treatment and/or diagnosis. I acknowledge that this consent will remain in effect until I revoke it in writing and present this document or the minor reaches the age of 18 years.

By signing below, I certify that I have read the above information and have had any questions answered. MY signature also certified my understanding and agreement with the above information:

Parent/Legal Guardian Signature: ______________________________________ Date: _______________

Printed Name: ____

Consent to Treatment:

Communication:

Heartland Weight Loss will periodically correspond with patients using SMS (text), phone, and/or email. SMS (text) messaging and email are not considered secure so private health information will not be discussed using these modalities. However, they may be used to communicate information about scheduling, special events, newsletters, and any other non-medical correspondence.

Initial:__________

Confidentiality:

From time to time, patient information may be used in the collection of statistics to compare results and improve the treatment of obesity. This de-identified information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

Initial:__________

Billing:

Heartland Weight Loss is currently contracted with all major commercial insurance companies. It is your responsibility to verify your benefits prior to your first appointment. If your insurance company denies payment due to out-of-network status or because the service is not considered a covered benefit under your individual insurance plan, you will be held responsible for the full amount once they have processed the claim. If services are not covered by your plan, you have the option to switch to cash-pay going forward but once a claim has been submitted to insurance, we must collect the amount owed. Any balance assigned to you by your insurance company must be collected at your next visit. If you choose not to submit visits to insurance, our cash prices are as follows:

- new patient visit: $200
- follow-up visit: $ 100
- EKG: $35
- body composition analysis: $25

Initial:__________

Scheduling:

There will be a $50 fee added to your account for no-show appointments and/or appointments that are canceled less than 48 hours prior to the scheduled time. If you are more than 10 minutes late for your appointment, it will be rescheduled and the $50 fee will be applied.

Initial:__________

Parent/Legal Guardian Signature: ______________________________________ Date: _______________

Printed Name: ____

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

If you have any questions please contact a HIPAA Compliance Committee Member at (913)620-1616

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you an opportunity to have a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must let us know in writing if you change your mind.

YOU HAVE THE RIGHT TO:

Get a copy of your paper or electronic medical record.

- You can ask to see or get an electronic or paper copy of your medical records & other health information we have about you.
- To obtain a copy of your medical record, you must contact our office request & complete a medical record release form.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost based fee.

Correct your paper or electronic medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- To request a correction, you must contact our medical records representative & request a Chart Amendment Form.
- We may say “No” to your request, but we’ll tell you why in writing within 60 days.

Request Confidential communication.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- To request confidential communication, please complete the special instructions area of the PHI Restriction Form. Your request must specify how or where you wish to be contacted.
- We will say “Yes” to all reasonable requests.

Ask us to limit the information we share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, & we may say “No” if it would affect your care.

Get a list of those with whom we’ve shared your information.

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we share it with, & why.

- We will include all the disclosures except those about treatment, payment & health care operations, & certain other disclosures (such as any you asked us to make).
- We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request an accounting of disclosures, make your request in writing, to: **Heartland Weight Loss,** 14205 Metcalf Avenue, Overland Park, KS 66223

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice any time. We will provide you a paper copy promptly.
- You can view an electronic copy via www.heartlandweightloss.com

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights & make choices about your health information.
- We will make sure the person has this authority & can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated.

- If you believe your privacy rights have been violated, you may file a complaint with our office or with the US Department of Health & Human Services.
- To file a complaint with our office, contact our office for a HIPAA Complaint Form. You will not be penalized for filing a complaint.
- To file a complaint with the US Department of Health & Human Services, contact their office at 200 Independence Avenue SW, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaint/.

YOU HAVE SOME CHOICES IN THE WAY THAT WE USE AND SHARE INFORMATION:

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, & we will follow your instructions.

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are unable to tell us your preference, for example, if you are unconscious, we may go ahead & share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious & imminent threat to health or safety.
In the below-described instances we will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy Notes

WE MAY USE AND SHARE YOUR INFORMATION AS WE:

Provide medical Treatment: We can use your health information & share it with other professionals who are treating you. *Example: A doctor treating you for diabetes asks another doctor about your overall health condition*
Run our organization: We can use & share your health information to run our practice, improve your care, & contact you when necessary. E*xample: We use health information about you to manage your treatment & services.*
Bill for your services: We can use & share your health information to bill & get payment from health savings plans or other entities. *Example: We give information about you to your health savings plan so it will pay for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health & research. We have to meet many conditions in the law before we can share

your information for these purposes. For more info see: www.hhs.gov/ocr/privacy/hipaa/undertanding/consumers/index.html.

Help with public health & safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research

Comply with the law

- We will share information about you if state or federal laws require it, including with the Dept of HHS if it wants to see that we're complying with federal privacy law.

Respond to organ & tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address worker's compensation, law enforcement, & other government requests

- We can use or share health information about you for worker's compensation claims.
- We can use or share health information about you for law enforcement purposes or with a law enforcement officer.
- We can use or share health information about you with health oversight agencies for activities authorized by law.
- We can use or share health information about you for special government functions such as military, national security, & presidential protective services.

Respond to lawsuits & legal actions

- We can share health information about you in response to a court or administrative order, or in a response to a subpoena.

CHANGES TO TERMS OF THIS NOTICE

We can change the terms of this notice, & the changes will apply to all information we have about you. The new notice will be available upon request.

I have read and understand the HIPAA policy:

Parent/Legal Guardian Signature: ______________________________________ Date: _______________

Printed Name: ____