Patient Health Information and Privacy Policy: This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's right concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

https://www.hhs.gov/sites/default/files/privacysummary.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.

2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.

3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Assignment of Benefit and Release of Records: The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

SMS Consent Communication:
Information (Phone Numbers) obtained as part of the SMS consent process will not be shared with third parties for marketing purposes.

Patient Payment Responsibility: All payments must be made by cash, check, or credit card on the **day services are rendered** unless we agree to bill your insurance directly based upon prior approval and authorization. If we do bill your insurance directly and for any reason your insurance company sends you the check, you are legally and contractually obligated to forward such funds and related explanation of benefits to our office upon receipt. Any dishonored checks will be charged all outstanding funds, plus a $25 processing fee and any related bank charges, must be paid within five (5) days of notice. You will be responsible for all credit/debit card fees (less than 3%) on all card transactions.

Individual's Financial Responsibility: I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments, deductible, coinsurances are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

Initial ________ Date ____________ Signature ____________________________

Patient Cancellation/Missed Appointment Policy: Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

Cancellation of an Appointment : In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 8 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Secondary to high demand for Saturday appointments, you must cancel your Saturday appointment by 12:00pm Friday.

How to Cancel Your Appointment: Please call to cancel appointments, if you do not reach the receptionist you may leave a detailed message on the voicemail, please leave your full name, phone number, day and time of appointment. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy: A "no-show" is someone who misses an appointment without calling 8 hours in advance to cancel. "Noshows" inconvenience those individuals who need access to medical care in a timely manner, as well as the clinicians. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of $50.00 for regular appointments. All fees must be paid prior to future appointments.

Late Cancellations: Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 8 hours in advance of your scheduled appointment time will not be assessed a

cancellation fee. All fees must be paid prior to future appointments.

I have read and agree to my payment and financial responsibilities as a patient and the patient cancellation and missed appointment policy. Even though I may be paying for services rendered with cash, check, or insurance.

Consent to Save Payments: I give permission for Jaguar Therapeutics to save payment information, including credit / debit cards. Jaguar Therapeutics or others acting on the Jaguar Therapeutics behalf will not charge cards without direct consent from You. If You do not wish for Jaguar Therapeutics to save payment information, specifically card information, You should write “Decline” in the space below.

Social Media: Our Clinic has a therapist-run social media account. This is a space where we share photos and videos of our daily activities and excellent work. Please indicate if you approve or disapprove of your photo/video being featured on our social media pages.

I grant to Jaguar Therapeutics, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I agree that Jaguar Therapeutics may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

Initial ____________ **Date ____________** **Signature ____________________________**

SMS Terms and Conditions

1- SMS Consent Communication:

Information (Phone Numbers) obtained as part of the SMS consent process will not be shared with third parties for marketing purposes.

2- Types of SMS Communications:

If consent has been given to receive text messages from Jaguar Therapeutics, messages may be received related to the following:

Appointment reminders

Follow-up messages

Billing inquiries

Example: "Hello, this is a reminder of your upcoming appointment with Jaguar Therapeutics at 3305 Rice St on 2/21/25 at 11am. Reply STOP to opt out of SMS messaging at any time."

3- Message Frequency:

Message frequency may vary depending on the type of communication. For example, up to 8 SMS messages per week may be received related to appointments, billing or follow up questions.

4- Potential Fees for SMS Messaging:

Standard message and data rates may apply, depending on the carrier's pricing plan. These fees may vary if the message is sent domestically or internationally.

5- Opt-In Method:

Opt-in to receive SMS messages from Jaguar Therapeutics can be done in the following ways:

By filling out a paper form

6- Opt-Out Method:

Opting out of receiving SMS messages can be done at any time by replying "STOP" to any SMS message received. Alternatively, direct contact can be made to request removal from the messaging list.

7- Help:

For any issues, reply with the keyword HELP. Alternatively, help can be obtained directly from us at jaguartherapy.com

Additional Options:

If SMS messages are not desired, the SMS consent box on forms can be left unchecked.

8- Standard Messaging Disclosures:

Message and data rates may apply.

Opt out at any time by texting "STOP."

For assistance, text "HELP" or visit our [Privacy Policy] and [Terms and Conditions] pages.

https://www.jaguartherapy.com/_files/ugd/aba618_4867a37f0ae14ecb8ffdd0af84fd9de9.pdf

Message frequency may vary