Verad Minute Clinic LLC: 5915 North Armenia Avenue, Tampa FL 33603

Registration Form

Patient Information

Last Name:_____ First Name: _____ MI: ___
Date of Birth:_____ Sex: [ ] Female: [ ] Male:
Home address: _____
City: _____ State: _____ Zip:_____

Billing Address: [ ] Same as home _____
City: _____ State: _____ Zip: _____

Ph (home): _____Ph (cell): _____ Ph(Work): _____
Email Address: _____
Emergency contact name: _____
Phone:_____ Relationship: _____

Plan:
One time enrollment fee of $150 per plan

Monthly subscription cost per person / family:

[ ]: Plan A : Ages 5 to 17 — $50/month
[ ]: Plan B: Ages 18 to 49 — $75/month
[ ]: Plan C: Ages 50 and above $85/month
[ ]: Plan D: Family Plan — $199/month
***All Plans include basic labs and select medications and annual Physicals. See page____ for details*

Authorization:

Billing option 1: Automatic fund transfer: *** please attach a voided check to this form*** Please note that it takes up to 3 days from the payment processing date before the charge posts to your bank account.

Name on the account: _____
Bank name: _____ Account type: [ ] checking [ ] savings
Account number: _____ Routing Number: _____

Billing Option 2: Credit or Debit Card:

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Please check which applies:
[ ] One-time registration fee; [ ] Monthly subscription fee; [ ] One-time registration and Monthly subscription.
Name on the card: _____
Card type: [ ] Visa [ ] Mastercard [ ] American Express(**3% charge applies**)
Card number: _____ Expiration: _____ CVV code:_____
Billing Address on card: _____
City_____ State:_____ Zip: _____

NOTE: monthly subscription fee will be charged on the 1st of every month unless other date indicated here: _____

Authorization

Your monthly subscription fee covers your wellness plus services specifically outlined in the Verad Minute Clinic services plan details. If additional services that are not listed on the covered plan are needed, we will discuss with the patient, additional fees if needed will be paid on the day of the services.

- By signing below, I hereby authorize Verad Minute Clinic to contact me using the information I have provided above.
- By signing below, I hereby authorize Verad Minute Clinic to initiate a charge to my credit card, debit card or bank account for my periodic membership fee. I understand that the transaction amount is the total of my care fee plus the care fees of any other individuals on my account.
- I understand that my membership in Verad Minute Clinic is continuous and that by signing below, I authorize recurring credit/debit charges or bank account funds transfers.
- I understand that a $30 fee will be charged to me for a declined credit card, debit card or for an automatic funds transfer transaction that is not honored.

Account holders Name:_____

Account Holders Signature:_____ Date: _____

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Patient agreement & Disclosure Statement

Terms

- I acknowledge and understand that I am voluntarily becoming a Verad Minute Clinic patient and that this agreement is non-transferable.
- I have reviewed the Verad Minute Clinic Patient Services Guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance, and that it provides only the health care services specifically described in the Verad Minute Clinic Patient Services plan details.
- I acknowledge and understand that I am responsible for the monthly subscription fee and any charges incurred for health care services performed outside of Verad Minute Clinic, including but not limited to emergency room, hospital and specialty services, imaging services or laboratory tests sent to third party labs.
- I acknowledge and understand that Verad Minute Clinic must maintain a record of my health information and must protect the privacy of my health information as per the terms of the Notice of Privacy Practices. I understand and acknowledge that this policy is available at veradminuteclinic.com or upon request.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a $50 late fee and that my service agreement may be terminated.
- I acknowledge and understand that my monthly subscription fee may increase based on the Verad Clinic age-based fee schedule. This increase would take effect the month after any qualifying birthday.
- I acknowledge and understand that I may terminate this Patient Agreement at any time and for any or for no reason by providing written notice to Verad Minute Clinic. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date that Verad Minute Clinic has received my written termination and refunded to me within thirty (30) business days.
- In addition, I acknowledge and understand that Verad Minute Clinic may terminate this Patient Agreement for cause due to non-payment of fees, or for unruly, threatening or inappropriate behavior by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and returned to me within thirty (30) business days. Verad Minute Clinic will not terminate this Patient Agreement solely on the basis of health status.

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- I acknowledge and understand that Verad Minute Clinic may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least sixty (60) days notice of such fee schedule changes

Rights & Responsibilities

- I understand that I have the right to receive accurate and easily understood information about Verad Minute Clinic health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Verad Minute Clinic will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Verad Minute Clinic, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must complete a written Service Cancellation Form. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Verad Minute Clinic health care clinician (s). I also understand that I am responsible for communicating clearly and respectfully with my clinician. Should I become dissatisfied with my care or Verad Minute Clinic services, I agree to notify Verad Minute Clinic immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all of my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my Verad Minute Clinic provider(s) and to have my health care information protected. I understand that Verad Minute Clinic will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting Verad Minute Clinic.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including

complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Verad Minute Clinic staff and to participate in the Verad Minute Clinic complaint and grievance process.

- In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Verad Minute Clinic health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Verad Minute Clinic health care clinician(s) of any health care services I receive outside of Verad Minute Clinic (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my Verad Minute Clinic care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Verad Minute Clinic patient and I agree to the terms outlined in this Patient Agreement.

SIGNATURE_____DATE: _____

PRINT NAME: _____
Signed by: [ ] Patient [ ] Parent [ ] Guardian

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Acknowledgement of Privacy Practices (HIPAA)

Acknowledgement

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Verad Minute Clinic's Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Verad Minute Clinic has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Verad Minute Clinic is not required to accept my requested restrictions, but if they are accepted then I understand that Verad will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at Verad Minute Clinic.

Authorization to Communicate Protected Health Information - Check all that apply:
[ ] Verad may leave a detailed message on voicemail at my home phone number: _____
[ ] Verad may leave a detailed message on voicemail at my cell phone number:_____
[ ] Verad may speak with another person (spouse, family member) about my medical condition including / excluding information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relation: _____Phone #: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Verad Minute Clinic should I change one or more of the telephone numbers listed above.

PATIENT SIGNATURE _____**DATE**:_____
PATIENTNAME: _____**DATEof BIRTH:**_____
PATIENT'S REPRESENTATIVE: _____**DATE:**_____
RELATION TO PATIENT: _____

For administrative use only: We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons: ☐Patientdeclined to sign ☐Emergency situation ☐Communicationbarriers
☐Other: _____