AVEDAMED®
Primary Care | Cardiology | Rheumatology

AvedaMed, LLC
2130 Millburn Ave, Ste A-4
Maplewood, NJ 07040
Phone: (973) 761-6111
Fax: (973) 761-6111
Info@AvedaMed.com
AvedaMed.com

CONSENT FOR MEDICAL SERVICES & FINANCIAL RESPONSIBILITY

I, _____ , *understand and agree that my below affixed signature* authorizes medical treatment and outlines my patient responsibilities regarding insurance billing and payment for services rendered by AvedaMed, LLC, and their affiliated providers and staff (hereinafter referred to as "Providers").

Consent for Medical Services: I voluntarily consent to undergo medical evaluations, diagnostic procedures, and treatments that are deemed necessary by my treating provider(s). I understand that I may decline or revoke consent for treatment at any time. I acknowledge that the Providers do not offer emergency medical services and that in the event of a medical emergency, I should seek care at the nearest hospital emergency department.

Prescription and Insurance Authorization: I authorize the Providers to access and review my prescription history and medication records for treatment and verification purposes. I affirm that the insurance information I provide is accurate and up to date. I agree to notify the practice promptly of any changes in my health insurance coverage or benefits.

Financial Responsibility: I agree to pay all required co-payments at the time of service, as well as any charges related to unmet deductibles or co-insurance. I am responsible for any unpaid costs due to inactive coverage or incorrect insurance information, payable within 60 days of notification. If my insurance provider sends payment directly to me, I will forward it to the Providers immediately. Any unpaid balance after 60 days may accrue interest up to 3% per annum, and if unpaid beyond 120 days, the Providers may initiate collections or legal actions.

Informed Consent: I confirm that I have had the opportunity to discuss the proposed treatment plan with my provider, including the **risks, benefits, and alternatives**, and that all questions have been answered to my satisfaction. I consent to proceed with care based on this understanding.

By signing below, I confirm that I fully understand and agree to the terms outlined herein, including the designation of my Authorized Representative, assignment of benefits, and granting of access to my insurance information.

Signature: _____ **Date:** _____

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ASSIGNMENT OF BENEFITS

I, _____ , the undersigned patient or legally authorized representative, hereby **designate AvedaMed, LLC**, and their affiliated providers, facilities, administrative agents, attorneys, and billing representatives (collectively referred to as "Providers") as my **Authorized Representative** for all purposes related to the coordination, administration, and enforcement of my health insurance benefits and medical claims.

This designation includes, but is not limited to, the following rights, powers, and privileges:

Assignment of Benefits: I assign to the Providers all rights and benefits under my insurance policy or health plan, including ERISA-governed plans, for services rendered. This includes the right to, bill, collect, appeal, litigate, or arbitrate denied or underpaid claims in my name or theirs.

Direct Payment Authorization: I authorize my insurance carrier or any responsible third-party payor to remit all payments directly to the Providers. If payment is sent to me in error, I agree to endorse and forward those funds immediately to the Providers.

Insurance Access & Disclosure: I grant the Providers full access to my insurance policy, coverage terms, eligibility information, and claims records. This includes rights to obtain, review, and submit all documents necessary for prior authorizations, appeals, benefit disputes, and reimbursement enforcement. **MY CARRIER SHALL NOT INTERFERE/DELAY THE FULFILLMENT OR ISSUANCE OF ANY SUCH REQUESTS MADE BY THE PROVIDERS.**

HIPAA Authorization: I authorize the release of my protected health information (PHI) to the Providers and their designated agents, including legal counsel, for treatment, billing, and administrative purposes related to any claim or coverage matter.

Authority to Act: I grant the Providers permission to initiate and pursue **appeals, grievances, arbitration, and legal action** on my behalf for any disputed, delayed, or denied medical claims, and to recover any interest or penalties owed under federal or state law.

Term: This agreement is effective immediately and remains valid unless revoked in writing. It applies to all past, current, and future services provided by the Providers.

Signature: _____ **Date:** _____

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PATIENT PRIVACY NOTICE

I, _____, acknowledge that I have been provided with and understand this Notice of Privacy Practices from AvedaMed, LLC, and its affiliated providers and staff (hereinafter referred to as "Practice"). This Notice describes how my medical information may be used and disclosed, and how I may access this information.

Use and Disclosure of Protected Health Information: The Practice may use and disclose my Protected Health Information (PHI) without my written authorization for purposes of treatment, payment, and healthcare operations. This includes coordination of care between providers, submission of insurance claims, billing activities, quality improvement initiatives, and administrative operations necessary to run the Practice. The Practice may also disclose my PHI when required by law, including for public health reporting, law enforcement requests, or regulatory compliance.

Minimum Necessary Standard: The Practice will limit the use, access, and disclosure of my PHI to the minimum amount necessary to accomplish the intended purpose. Access to my information is restricted based on staff roles and responsibilities.

Patient Rights: I understand that I have the right to access and obtain a copy of my medical records, request amendments to my health information, request restrictions on certain uses or disclosures, request confidential communications, and receive an accounting of disclosures of my PHI. I also have the right to file a complaint if I believe my privacy rights have been violated, without fear of retaliation.

Safeguards and Security Measures: The Practice maintains administrative, physical, and technical safeguards to protect my PHI. These include secure electronic systems, password protection, controlled access to records, staff training, and proper disposal of sensitive information. The Practice prohibits unauthorized discussions or sharing of PHI in public or unsecured environments.

Communication and Electronic Use: The Practice may communicate with me via phone, voicemail, email, or other methods provided by me. I understand that standard email or text messaging may not be fully secure, and I accept this risk unless I request alternative communication methods in writing.

Breach Notification: In the event of a breach involving my unsecured PHI, the Practice will notify me in accordance with applicable federal and state laws and will take appropriate corrective action.

Acknowledgment and Updates: I acknowledge that I have received this Notice of Privacy Practices and understand that the Practice reserves the right to update or modify this Notice at any time. Updated versions will be made available upon request and at the Practice location.

Signature: _____ **Date:** _____

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)/HIPAA RELEASE

I, _____ , authorize and agree that **the Healthcare Providers, Entities, and Individuals listed below are hereby granted permission to request and receive disclosures of any and all of my medical records or protected health information (PHI):**

- **AvedaMed, LLC**, its affiliated providers, and staff (collectively referred to as " Healthcare Providers")
    - "Healthcare Providers" may be defined as any other parties/entities directly involved in/or providing services and/or equipment for my care. This may include: (1) other healthcare providers involved in my ongoing care under this agreement, vendors of medical equipment, and/or any other entity, carrier, employer, or representative financing/providing medical insurance coverage or care to me in collaboration with my Healthcare Providers.
- **The below-listed individuals/Designated representatives/friends/or family (Must include their First and Last Name):**

  _____
  _____
  _____

Revocation: I may revoke this authorization at any time by submitting a written request to my "Healthcare Providers" Privacy Officer at 2130 Millburn Ave, Ste A-4, Maplewood, NJ 07040. Revocation will not affect actions taken before the request is received.

Notice of Privacy Practices: I acknowledge receipt of my "Healthcare Providers" Notice of Privacy Practices, which may change at any time. I may request the most up-to-date version of Privacy Practices by emailing my "Healthcare Providers" at Info@AvedaMed.com or by calling 973-761-6111

Authorization Duration: This authorization remains valid for three years from my last date of service with Providers. I understand that if my PHI is shared with entities not bound by HIPAA, it may no longer be protected by federal privacy laws.

Consent for Use: I understand that signing this authorization is not required to receive treatment and that I may request restrictions on the use of my PHI for treatment, payment, or operations. While Providers are not required to agree to these restrictions, any agreed limits are binding.

By signing below, I consent to the use and disclosure of my PHI for the purposes described above.

Signature: _____ **Date:** _____

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DIGITAL COMMUNICATION CONSENT

I, _____ **,** hereby grant consent to AvedaMed, LLC, their affiliated providers, and staff hereafter referred to as "the Clinic," to contact me via digital communication methods including but not limited to voice calls, SMS (text messages), automated reminders, email, and any other source deemed necessary by the Clinic, for the purpose of communicating information related to my upcoming medical appointments or associated information requiring communication between all parties involved.

By signing this consent form, I acknowledge and agree to the following terms:

The Clinic may send digital communications in various formats and with various content, including, but not limited to, appointment reminders, pre-appointment instructions, post-appointment follow-ups, and general healthcare-related information.

I confirm that I am the owner or an authorized user of the mobile phone number and/or email address provided below. I undertake to notify the Clinic immediately if I am no longer the owner or authorized user of the provided contact information.

I understand and agree that I am solely responsible for any message and data charges associated with receiving digital communications from the Clinic.

I acknowledge that I have the right to opt out of receiving digital communications from the Clinic at any time. I can do so by replying to any message with the word "STOP" or by notifying the Clinic in writing of my decision to opt out of digital communications.

Signature: _____ **Date:** _____