

## **PATIENT INFORMATION AND CONSENT DOCUMENTS**

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## DO YOU NEED AN INTERPRETER?

### **English**

Need an Interpreter? You have the right to an interpreter for your visit. If you need one, please call (718) 540-8682.

### **Russian (Русский)**

Нужен переводчик? Вы имеете право на переводчика во время вашего визита. Если вам нужен переводчик, пожалуйста, позвоните по телефону (718) 540-8682.

### **French (Français)**

Besoin d'un interprète ? Vous avez le droit à un interprète pour votre visite. Si vous en avez besoin, veuillez appeler le (718) 540-8682.

### **Haitian Creole (Kreyòl Ayisyen)**

Èske ou bezwen yon entèprèt? Ou gen dwa pou resevwa yon entèprèt pandan vizit ou. Si ou bezwen youn, tanpri rele (718) 540-8682.

### **Urdu (اردو)**

کیا آپ کو مترجم کی ضرورت ہے؟ آپ کو اپنے دورے کے دوران مترجم کا حق حاصل ہے۔ اگر آپ کو مترجم کی ضرورت ہو تو براہ کرم (718) 540-8682 پر کال کریں۔

### **Simplified Chinese 简体中文**

需要口译员吗？您有权在就诊期间获得口译服务。如需帮助，请致电 (718) 540-8682。

### **Arabic (العربية)**

. هل تحتاج إلى مترجم؟ لديك الحق في الحصول على مترجم أثناء زيارتك. إذا كنت بحاجة إلى مترجم، يرجى الاتصال على الرقم (718) 540-8682.

### **Nepali (नेपाली)**

के तपाईंलाई दोभाषेको आवश्यकता छ? तपाईंको भ्रमणको क्रममा दोभाषे पाउने अधिकार तपाईंलाई छ। यदि आवश्यक छ भने, कृपया (718) 540-8682 मा फोन गर्नुहोस्।

### **Hindi (हिन्दी)**

क्या आपको दुभाषिए की आवश्यकता है? आपकी यात्रा के दौरान दुभाषिया पाने का आपको अधिकार है। यदि आपको दुभाषिए की आवश्यकता हो, तो कृपया (718) 540-8682 पर कॉल करें।

### **Spanish (Español)**

¿Necesita un intérprete? Usted tiene derecho a un intérprete durante su visita. Si necesita uno, por favor llame al (718) 540-8682.

## CONSENT TO TREAT & ACKNOWLEDGE SERVICES

This form provides consent for medical care and participation in health services delivered by **Akido Medical**. These services may include wellness check-ins, follow-up care coordination, screening assessments, and referrals to in-network or community-based providers.

### Consent to Medical Treatment

I voluntarily consent to receive healthcare services provided by or coordinated through **Akido Medical**. These services may include, but are not limited to:

- In-person or telehealth consultations
- Vital sign collection and health screening
- Review of medications, labs, or recent health concerns
- Referral to other licensed providers or services as appropriate
- Care coordination with my existing providers (if applicable)

I understand that I can choose not to participate in any part of the exam or treatment and that I may ask questions at any time.

### Limitations and Emergency Care

I understand that **Akido Medical** does not provide emergency care or 24/7 services. If I experience a medical emergency, I will call 911 or go to the nearest emergency room.

### Communication and Care Coordination

I understand that my health information may be shared with other healthcare professionals or organizations (e.g., specialists, urgent care, PCPs) involved in my care, in compliance with HIPAA and relevant privacy laws. This may include referrals or communication to ensure I get the follow-up or specialty services I need.

If I already have a primary care provider, I understand that **Akido Medical** will aim to coordinate care without replacing or interfering with my ongoing provider relationship.

# USE OF TRANSCRIPTION AND ARTIFICIAL INTELLIGENCE (AI) TOOLS

We want to be transparent about how we use your Protected Health Information, also called “PHI.” This consent explains how Akido Medical (“we/us”) may use transcription services and artificial intelligence (AI) tools, and how we protect your privacy.

## Use of AI in Your Care:

- We sometimes transcribe conversations (spoken words) during your care, turning them into written notes using transcription services and AI tools.
- We also may use AI tools to help summarize, analyze, or assist in managing your medical records.
- Our goal is to improve care, make documentation more accurate, and streamline operations

## How your health information may be used:

Your protected health information (PHI) may be used or shared by us, or by our Business Associates (vendors, contractors) under contract, for:

- **Treatment** — to help your provider deliver care to you;
- **Payment** — to assist billing, insurance, or claims;
- **Health Care Operations** — to improve our services, auditing, staff training, quality assurance, risk management, and administration.

Additionally, your PHI may be used to train, refine, or improve AI systems (ours or those of our Business Associates). This means your data helps the AI “learn” patterns to become better over time (including, for example: improving transcription accuracy, clinical decision support, developing new healthcare technologies, analyzing population health trends and outcomes, and supporting quality improvement and safety initiatives that may benefit other patients).

## We will not:

- We will not allow AI to make final medical decisions. Your healthcare provider will review all draft clinical notes and recommendations and make the final decision about your diagnosis and treatment.
- We will not use or share your PHI for marketing or sell it to third parties without your explicit written authorization.
- We will not store the voice recordings of your conversations with your health care provider, only the transcript of your conversation is saved

## Confidentiality and Data Privacy:

- We comply with HIPAA which requires safeguards, limits on use/disclosure, your rights to access, amend, and get an accounting of disclosures of your PHI.
- Our Business Associates must agree (by contract) to abide by these same privacy and security protections.

## Your Rights:

- You have the right to ask questions about how the transcription and AI systems work and how they may be used in your care.
- You have the right to refuse the use of transcription and AI technology in your diagnosis and treatment. If you decline, we may limit or not use certain AI or transcription tools, though your medical care will continue.
- You may withdraw your consent for future at any time. If you choose to do so, please inform your healthcare provider. We will give you a form to complete. Please note that withdrawal will not affect data already used pursuant to this consent prior to your withdrawal.

### **Acknowledgment & Consent**

By signing below:

- You confirm you have read (or had read to you) this consent form and understand it.
- You agree that your PHI may be used with transcription and AI tools, including for: training and improvement that may benefit other patients, medical research, population health analysis or healthcare quality improvement initiatives, by us and our business associates.
- You understand your rights and that consenting is voluntary.

# PATIENT RIGHTS & RESPONSIBILITIES

## Patient Rights

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly if you are admitted to the hospital.
3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risk involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services.
7. Be advised if the health practitioner is acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures, and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Our practitioners who provide care shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reasons for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed.

12. Confidential treatment of all communications and records pertaining to your care and stay in the health facility. You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual, or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form as used as a means of coercion, discipline, convenience, or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Examine and receive an explanation of your bill regardless of the source of payment.
17. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.
18. File a grievance. If you want to file a grievance with us, you may do so by writing or by calling **Akido Medical's** Patient Services at (718) 540-8682. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.
19. File a complaint with the Medical Board of New York regardless of whether you use our grievance process. You may file a complaint here: <https://www.op.nysed.gov/>

## Patient Responsibilities

You have the responsibility to:

1. Provide accurate and complete information as possible about present medical complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
2. Report unexpected changes in your medical condition to your medical providers.
3. Inform your doctor or staff when you do not understand a proposed treatment plan and what is expected of you.
4. Cooperate with the agreed upon treatment plan recommended by your doctor and follow the instructions of your doctors and medical staff.
5. Keep appointments to the extent possible or notify us if you are unable to do so.
6. Accept the consequences of any refusal of treatment after you have thoroughly discussed the treatment plan with your doctor and have understood the possible consequences of refusal.
7. Provide financial information as necessary to qualify for healthcare benefits.
8. Request health information and/or education as needed.
9. Be considerate and respectful of the rights and property of other patients.
10. Patients are expected to always conduct themselves respectfully; any form of violence, threats, or inappropriate behavior will not be tolerated and may result in immediate removal from the premises and possible dismissal from the practice

# HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## **YOUR RIGHTS**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record:

1. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
2. 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.

### Ask us to correct your medical record:

1. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
2. We may say 'no' to your request, but we'll tell you why in writing within 60 days.

### Request confidential communications:

1. 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.
2. We will say 'yes' to all reasonable requests.

### Ask us to limit what we use or share:

1. You can ask us not to use or share certain health information for treatment, payment, or our operations.
2. We are not required to agree to your request, and we may say 'no' if it would affect your care.
3. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
4. We will say 'yes' unless a law requires us to share that information.

### Get a list of those with whom we've shared information:

1. 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 shared it with, and why.
2. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice:

1. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you:

1. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

2. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated:**

1. You can complain if you feel we have violated your rights by contacting us using the information on the back page.
2. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
3. We will not retaliate against you for filing a complaint.

**YOUR CHOICES**

For certain health information, you can tell us your choices about what we share. 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, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

1. Contact you via your preferred method. Understand that certain communication methods, like email, can involve security risks (for example, interception or unauthorized access)
2. Share information with your family, close friends, or others involved in your care
3. Share information in a disaster relief situation
4. Include your information in a directory  
*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

1. Marketing purposes
2. Sale of your information
3. Most sharing of psychotherapy notes

**In the case of fundraising:**

1. We may contact you for fundraising efforts, but you can tell us not to contact you again.

**OUR USES AND DISCLOSURES**

How do we typically use your information?

**We typically use or share your health information in the following ways:**

1. **Treat you:** We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
2. **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
3. **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

## **OTHER USES**

### **How else can we share your information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues:**

1. 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:**

1. We can use or share your health information for research.

### **Comply with the law:**

1. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests:**

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

### **Work with a medical examiner or funeral director:**

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

### **Address workers' compensation, law enforcement, and other government requests:**

1. We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions:**

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

### **De-identified PHI:**

1. We may deidentify your PHI. This means we remove any information that can be used to identify you. De-identified data is not subject to this Notice.

### **Substance Use Disorder Records:**

1. Substance use disorder (SUD) records may be used and disclosed for treatment, payment, and health care operations as permitted by law. They may not be used or disclosed for civil, criminal, administrative, or legislative proceedings against you, nor for law enforcement purposes, without your specific authorization or as otherwise expressly permitted by law.

### **Artificial Intelligence (AI) tools:**

1. We may use your personal information for artificial intelligence and machine learning purposes in the support of patient treatment and our health care operations.

### **Sale of the Medical Practice:**

1. In the event this medical practice is sold or merged with another organization, your health information (your record) will be transferred to the new owner. You will maintain the right to request copies of your record or request copies of your record to be sent to another doctor or medical group.

**Health Information Exchanges:**

1. We may participate in state or private health information exchanges designed to improve the quality of healthcare by helping the secure exchange of electronic health information between and among several healthcare providers or other healthcare entities. These exchanges contribute to improved and better-coordinated healthcare outcomes for our patients, including in emergent care situations. This means we may share information we obtain or create about you with other healthcare providers or entities (such as hospitals, doctors' offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information).

If you would like more information on any state or private health information exchange in which we may participate, or would like information on how to opt out of these exchanges, please email [compliance@akidolabs.com](mailto:compliance@akidolabs.com)

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- 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 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. Let us know in writing if you change your mind.

**Changes to the Terms of This Notice:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

**This Notice of Privacy Practices applies to** Akido Medical, all locations and offices, as well as Business Associates Akido Medical has contracted with to provide administrative or operational services.

This notice applies to all protected health information, including but not limited to information obtained via our speech to text transcription process and location tracking services.

**Privacy Officer:** Candace Bonnis, CHC, CHPC

Phone: (213) 348-6051

Email: [compliance@akidolabs.com](mailto:compliance@akidolabs.com)

**This Notice is Effective February 1, 2026**

# NON-DISCRIMINATION CONSENT & ACKNOWLEDGEMENT

Akido Medical complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Akido Medical, PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Akido Medical:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Akido Medical's Patient Services at (718) 540-8682 from 9 a.m. to 5 p.m. E.S.T, Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

If you believe that Akido Medical has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Akido Medical's Patient Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

# TELEHEALTH CONSENT

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care. This “Telehealth Informed Consent” informs the patient (“patient,” “you,” or “your”) concerning the treatment methods, risks, and limitations of using a telehealth platform.

## Services Provided

Telehealth services offered by **Akido Medical**, and **Akido Medical**'s engaged providers (our “Providers” or your “Provider”) may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the “Services”).

Akido Labs, Inc. does not provide the Services; it is a Business Associate of **Akido Medical** and it performs administrative, payment, and other supportive activities for the **Akido Medical** and its Providers.

## Electronic Transmissions

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
  - asynchronous communications
  - two-way interactive audio in combination with store-and-forward communications; and/or
  - two-way interactive audio and video interaction
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;
- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;
- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

## Expected Benefits

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you.
- Convenient access to follow-up care.
- More efficient care evaluation and management.

## Service Limitations

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT AKIDO LABS, INC., **AKIDO MEDICAL**, OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE PROVIDER.**

## Security Measures

The electronic communication systems we use will incorporate network and software security protocols designed to protect the confidentiality of patient identification and imaging data and will include measures designed to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

## Possible Risks

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact **Akido Medical** at (718) 540-8682 or careteam@akidolabs.com.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

### Patient Acknowledgments

I further acknowledge and understand the following:

1. I understand that I may be asked to provide my identification and confirm my physical location prior to or during the telehealth visit.
2. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.
3. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.
4. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record.
5. **Akido Medical** will take steps to make sure that my health information is not seen by anyone who should not see it. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state. I consent to **Akido Medical** using and disclosing my health information for purposes of my treatment (e.g., prescription information) and care coordination, to receive reimbursement for the services provided to me, and for **Akido Medical's** health care operations.
6. Dissemination of any patient-identifiable images or information from the telehealth visit to researchers or other educational entities will not occur without my consent unless authorized by state or federal law.
7. There is a risk of technical failures during the telehealth visit beyond the control of **Akido Medical**.
8. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.
9. Persons may be present during the telehealth visit other than my Provider who will be participating in, observing, or listening to my consultation with my Provider (e.g., in order to operate the telehealth technologies). If another person is present during the telehealth visit, I will be informed of the individual's presence and their role.
10. My Provider will explain my diagnosis and its evidentiary basis, and the risks and benefits of various treatment options.
11. I understand that by creating a treatment plan for me, my Provider has reviewed my medical history and clinical information and, in my Provider's professional assessment, has made the determination that the provider is able to meet the same standard of care as if the health care services were provided in-person when using the selected telehealth technologies, including but not limited to, asynchronous store-and-forward technology.
12. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting **Akido Medical** at (718) 540-8682 or careteam@akidolabs.com. A copy will be provided to me at a reasonable cost of preparation, shipping and delivery.
13. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that I can access, amend, or review my health information at any time.
14. There is no guarantee that I will be issued a prescription and that the decision of whether a prescription is appropriate will be made in the professional judgement of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.
15. There is no guarantee that I will be treated by a **Akido Medical** provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.

# PATIENT CONSENT FOR REPORTING HEALTH CONDITIONS IMPACTING DRIVING SAFETY

## Purpose

As part of our commitment to your health and public safety, we are sometimes required—or ethically compelled—to report certain medical conditions that may impair your ability to drive safely, such as seizures, loss of consciousness, or other significant impairments.

## What This Consent Covers

By signing this form, you give Akido Medical permission to report to appropriate authorities, programs, or affiliated partners any medical conditions that may impair your ability to operate a vehicle safely. This may include:

- Seizure activity or seizure disorders
- Blackouts, fainting, or syncope
- Significant vision or motor impairment
- Other conditions as determined by medical judgment to pose a risk while driving

## Who We May Report To

- Your licensing authority or state Department of Motor Vehicles (if applicable)
- Relevant occupational health entities (i.e., IDG, WBF)
- Your primary care provider or other treating physicians (if relevant and permitted)

## Your Rights

- You have the right to ask questions and receive more information about what might be reported.
- You may revoke this consent at any time by submitting a written request, except where actions have already been taken based on prior consent.
- Revocation may affect your participation in programs that require health clearance for driving.

## Confidentiality

Only the minimum necessary information will be shared to ensure safety and compliance with public health requirements. This consent does not authorize disclosure of your entire medical record.

## Acknowledgment and Signature

I understand and agree that Akido Medical may report certain health conditions that could impair my ability to drive safely. I understand the purpose and limits of this consent and acknowledge that this is being done to protect my safety and that of others on the road.

## PATIENT FINANCIAL RESPONSIBILITY FORM

We are committed to providing the best possible medical care and medical experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.

**Non covered services:** patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

**Correct insurance information:** you are responsible for providing us with the correct and updated information about your health insurance it is your responsibility to notify us immediately of a change to your health insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

Payment is required at the time of service: you are responsible for paying deductibles, Co- payments, Co-insurance, and other Out-Of-Pocket expenses not covered by your insurance plan at the time of service. If we are unable to verify your insurance coverage, you will be asked for payment period in addition to cash payments and checks, we also accept most major credit debit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

Any payments received may be applied to any unpaid bills for which the patient or legal guardian/conservator is liable. After 90 days, all balances assigned as patient responsibility may be subjected to collection efforts.

**Legal guardian/ Conservator:** the patients legal guardian, if a minor, or conservator, if an incapacitated adult, is responsible for the payment of co-pays, Co-insurance, deductibles, and all procedures or treatments not covered by their insurance plan.

**Missed appointments:** missed appointments without 24-hours advanced notice will result in a \$50 charge per occurrence and the patient may be subject to discharge from the practice. Please give us the courtesy of 24-hour advance notice to reschedule your appointment.

**Administrative charges:** patients may incur and are responsible for the payment of additional charges at the discretion of Akido Medical. The charges may include, but are not limited to, (subject to change at any time).

- charge for returned checks is \$25 bullet point charge for copying and distribution of patient medical records is \$25.
- charge for forms completion, including but not limited to disability and FMLA forms is \$35.
- charge for extensive phone consultations and slash or after-hours phone calls requiring diagnosis, treatment or prescriptions. Charged at the discretion of the physician.

**Patient/legal guardian/ conservator authorization (by my signature below):**

I hereby authorize Akido Medical to release all medical records and other information acquired during my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care period.

I hereby authorize assignment of financial benefits directly to Akido Medical and any associated health care entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by the insurance plan are patient/ legal guardian/conservator responsibility. I also understand that account balance is not paid within 90 days from the final statement date may be sent to a collection agency.

I authorize Akido Medical and the collection agency personnel to communicate with patient/legal guardian/conservator by mail, telephone (including cell phone) and/ or e-mail according to the contact information I have provided in the patient registration information.

I have read, understand, and agree with the policies and provisions outlined in this patient financial responsibility policy period.

# ADDITIONAL INFORMATION

## Physician License & Profile Information

### 1. NOTICE TO PATIENTS

To file a complaint against a physician or physician assistant in New York, contact the Office of Professional Medical Conduct (OPMC) by downloading, completing, and mailing the official complaint form (Form DOH-3867) to the NY State Department of Health, 433 River Street, Suite 1000, Troy, NY 12180. Complaints must be in writing and should detail the misconduct, including names of witnesses and supporting documents.

### 2. **The Open Payments Database** is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

It can be found at <https://openpaymentsdata.cms.gov>.

# ACKNOWLEDGEMENT AND CONSENT

## *SIGNATURE PAGE*

**I confirm that I have received and read the patient documents. I had the opportunity to ask questions, and if I asked questions, my questions were answered to my satisfaction.**

**By signing below, I acknowledge my understanding of the patient documents and give my consent for the documents listed below.**

- Consent to Treat and Acknowledge Services
- Use of Transcription and Artificial Intelligence (AI) Tools
- Patient Rights and Responsibilities
- HIPAA Notice of Privacy Practices
- Non-discrimination Consent Acknowledgement
- Telehealth Consent
- Patient Consent for Reporting Health Conditions Impacting Driving Safety
- Patient Financial Responsibility Form

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Patient or Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to patient**