

**Mark H. Lowitt, M.D., LLC  
Nicoleta Negoita MS, PA-C  
Juan (Julia) Liu, PhD, MMS, PA-C  
Carolyn Blair MMS, PA-C**

**GBMC Physicians Pavilion North  
(Tulip Parking Garage)  
6535 N. Charles Street, Suite 200  
Baltimore, MD 21204  
Phone: 410-321-1195  
Fax: 410-321-1197**

Welcome to our practice!

Please complete the enclosed forms and bring them and your Medicare and insurance cards with you to your appointment. Completion of the forms in advance and arriving 15 minutes prior to your scheduled appointment time will speed your check-in process and will ensure that your appointment runs smoothly. Please have your forms completed before you arrive. If you wait until the time of your visit to complete your forms we will not be able to see you on time.

If the patient is not competent to make medical decisions for him/herself, an individual with medical power of attorney must accompany the patient to the visit.

If the patient is hearing-impaired or does not speak English, we will gladly provide interpreting services at no charge.

As it can be difficult to find parking on the GBMC campus at certain times of day, please be sure to allow an extra 15 minutes to your anticipated travel time.

Missed Appointment Policy: Please notify us as soon as possible if you are unable to keep your appointment. We reserve the right to charge a **fee of \$50.00 for missed appointments (“no shows”)** and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. Patients who miss three appointments without notifying us within 24 hours will be discharged from the practice.

If you are coming for a full skin exam or for a facial skin problem, please do not wear facial makeup.

If you have any questions or concerns, please do not hesitate to give our office a call.  
We look forward to seeing you!

Sincerely,



Mark H. Lowitt M.D.

**PATIENT NAME** \_\_\_\_\_

**PRIMARY CARE PROVIDER** \_\_\_\_\_

**Preferred Pharmacy Name, address, phone** \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Any bad/allergic reaction to: (Circle) **Latex / Lidocaine / Epinephrine /Betadine /Iodine/Adhesives /Bacitracin/Neosporin**

List all medications you are currently taking (including prescriptions, over-the-counter meds, Vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

PAST MEDICAL HISTORY	YES	NO		YES	NO
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
BPH (large prostate)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>			
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<b>Pacemaker/defibrillator?</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Fainting with procedures?</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Allergies / Hay Fever</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Hepatitis B / C / HIV</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Artificial Joint (when?)</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Artificial Heart Valve</b>	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid disease (hyper or hypo)? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
			Leukemia/Lymphoma		
			Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			<b>MRSA</b>	<input type="checkbox"/>	<input type="checkbox"/>
			Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			OTHER LIST BELOW	<input type="checkbox"/>	<input type="checkbox"/>

List any other medical diseases or conditions:

List surgical procedures you have had:

	YES	NO	DETAILS
Have <b>you</b> ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell Squamous Cell Melanoma (circle)
Has anyone in your <b>family</b> had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell Squamous Cell Melanoma (circle)
Acne / actinic keratosis / eczema / precancerous moles / psoriasis? (please circle)			
Do you have problems with Bleeding / Healing/ Scarring? (circle)			
Fever / night sweats / joint pain / headache? (circle)			
Shortness of breath / cough / abdominal pain (circle)			

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_  
 Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Are you: Single  Married  Separated/Divorced  Widowed  LGBT   
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_  
**Occupation/School?** \_\_\_\_\_ **Hobbies?** \_\_\_\_\_

**Patient Signature and Date** \_\_\_\_\_ **Reviewed by** \_\_\_\_\_

# MARK H. LOWITT, M.D., LLC      OFFICE FINANCIAL POLICY

(5/6/2019)

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are Medicare Participating providers. We will bill Medicare and Medigap carriers. You will be responsible for payment of: a) The annual deductibles; b) Copayments and/or coinsurance c) Charges for noncovered or cosmetic services (You will be asked to sign an Advance Beneficiary Notice of Liability (ABN) Form in the event that a service is provided which we know is not covered by Medicare.)  
You will be sent a statement indicating your responsibility.

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance. You will be expected to pay the balance within 30 days of the statement date.

2. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of: a) Copayments, b) Charges for noncovered or cosmetic services.

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

3. For patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:  
We will file both your primary and secondary insurance as a courtesy. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. You will be expected to pay the balance within 30 days of the statement date.
  - a. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to pay 80% of the bill on the day of service. This can be done by cash, check, Mastercard, Visa Discover, and American Express. We will still notify your insurer of the visit and the amount that you paid, which may therefore be applied to your deductible, or which may be refunded to you, in all or in part, should the insurer choose to do so based on your particular plan. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Any balance remaining after your primary carrier has paid will be billed to you and is due and payable within 30 days of the statement date.

#### 4. MISSED APPOINTMENT POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a **fee of \$50.00 for missed appointments ("no shows")** and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. A fee of \$100.00 will be applied for missed excisions. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Three "no shows" may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

5. Returned Check Fee: There will be a \$35 fee for checks returned for any reason.
6. Referrals: If your insurance company requires a referral, it is your responsibility to have the referral at the appointment.
7. Changes in Insurance: It is your responsibility to make sure that our office has your CURRENT insurance information at the time of your appointment.

**Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.**

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*Patient signature*

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*Date*

## Mark H. Lowitt, MD, LLC

### A Message From Our Billing Service

Dear Patient,

Medical Billing Solutions has been retained by Dr. Lowitt's office to handle all billing and processing of claims to insurance companies. Please make payment to Dr. Lowitt, listed on the "Make Checks Payable To:" portion of your bill. Send your payment to the address noted on the statement.

**If you have any questions about the status of your account, do not call the doctor's office--- Call us directly at 410-876-1115, ext. 302**

The office is open Monday – Thursday, 9:00 am – 4:00 pm, Eastern Standard Time.

Should the answering machine answer your call, leave a message being sure to include your phone number with the area code. To expedite us returning your call, be sure to include the following:

1. Your name
2. The full name (clearly spell the name) of the patient
3. The patient's date of birth
4. Dr. Lowitt's name
5. The date of the office visit you are calling about
6. A brief statement of the problem
7. A daytime as well as a nighttime phone number.

For patients with secondary / supplemental insurance...

As a courtesy, our Billing Service will automatically file to your secondary/ supplemental insurance carrier after we receive payment from your primary insurance. If you receive a bill and have any questions, please call us at the number shown above to discuss the balance.

## Medicare Patient Information

**Patient Name:** \_\_\_\_\_ **Preferred Nickname** \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Female Male Language preference \_\_\_\_\_

Race: White / Black / Asian /  Other \_\_\_\_\_ Ethnicity  Hispanic/Latino

Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code

Phones: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

**Please print your name as it appears on your Medicare Card:** \_\_\_\_\_

**Medicare Policy Number as it appears on your card.** \_\_\_\_\_

**Referring Physician** Name: \_\_\_\_\_ Phone # \_\_\_\_\_

**Emergency Contact** : Spouse/Relative/Friend: \_\_\_\_\_ Phone: \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family or friends?**

Yes No If yes, please provide name(s) and phone number(s) below:

Name(s) (relationship), phone(s): \_\_\_\_\_

### **Please Sign So We May Have Your Medicare Authorization On File:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

## Payment Policy

**Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and 20% coinsurance. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

**Note:** If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

## Medicare Patient Information Page 2

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
<input type="checkbox"/>	<input type="checkbox"/>	Are you covered by a HMO / PPO which makes Medicare secondary?
<input type="checkbox"/>	<input type="checkbox"/>	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you or your spouse work and have coverage through the insurance at your job?
<input type="checkbox"/>	<input type="checkbox"/>	Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
<input type="checkbox"/>	<input type="checkbox"/>	Are you presently receiving Workers' Compensation?
<input type="checkbox"/>	<input type="checkbox"/>	Is the illness or injury you are coming to this office for the result of work-related causes?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have medical assistance through Welfare or state-aid?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Medicare Advantage Plan?

If you answered YES to ANY of the above questions, Explain: \_\_\_\_\_

\_\_\_\_\_

### Supplemental (MEDIGAP) Insurance

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (MEDIGAP coverage)

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_

### Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: \_\_\_/\_\_\_/\_\_\_ Signature: \_\_\_\_\_

**May we leave personal medical information on your voicemail?**

YES    NO

**May we email personal medical information to you?**

YES    NO

**Would you prefer appointment notification by phone, email, or text?**

Phone    Email    Text

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I am a patient of Mark H. Lowitt. I acknowledge receipt of Mark H. Lowitt, MD, LLC's Notice of Privacy Practices.

\_\_\_\_\_  
**Patient / Guardian Signature**

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

## **SUMMARY OF PRIVACY PRACTICES**

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: 9/21/2013

Effective Date: Immediately

**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.**

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As your patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.



## 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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

# Discrimination is Against the Law

Mark H. Lowitt, MD, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Mark H. Lowitt, MD, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Mark H. Lowitt, MD, LLC Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
  - 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
  - Information written in other languages

If you need these services, contact **Bobbi W., Front Desk Lead.**

If you believe that Mark H. Lowitt, MD, LLC 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 in person or by mail, fax, or email with:

**Mark H. Lowitt, MD**

**6535 N Charles St., Suite 200, Baltimore, MD, 21204**

**Ph. 410-321-1195**

**Fax 410-321-1197**

[bobbi@drmarklowitt.com](mailto:bobbi@drmarklowitt.com)

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, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Barbara Holland, Regional Manager Office for Civil Rights  
U.S. Department of Health and Human Services  
150 S. Independence Mall West Suite 372,  
Public Ledger Building Philadelphia, PA 19106-9111  
Customer Response Center: (800) 368-1019  
Fax: (202) 619-3818 TDD: (800) 537-7697  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

**MARK H. LOWITT, M.D., LLC**

GBMC Physicians Pavilion North  
6535 N. Charles Street  
Suite 200  
Baltimore, MD 21204

Phone: 410.321.1195  
Fax: 410.321.1197

**INFORMED CONSENT FOR DERMATOLOGY TELEMEDICINE SERVICES**

Patient Name: _____	Date of Birth: _____
Location of Patient: State of Maryland: Y ___ N ___	Date Consent Discussed: _____, 202__
Name of Treating Healthcare Provider(s): _____ _____	Alternative contact for Patient: Telephone: _____ E-mail: _____
SEE ABOVE FOR CONTACT INFORMATION	

**Introduction**

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telemedicine services offered by Mark H. Lowitt, M.D., LLC ("Dr. Lowitt's Office") may also include chart review, remote prescribing, appointment scheduling, health information sharing, and non-clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; (2) images and asynchronous communications; (3) live two-way audio and video; (4) interactive audio with store and forward; and (5) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

- Improved access to care by enabling you to remain in your home while the provider from Dr. Lowitt's office consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist as appropriate.

**Possible Risks:**

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
- Our provider may determine that the transmitted information is of inadequate quality (e.g., poor resolution of images), to allow for appropriate medical decision making by the provider, thus necessitating a rescheduled telemedicine consult or the necessity for an in-office consultation.
- In rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- Our providers will not be able to perform certain diagnostic procedures during your telemedicine consultation, which may require scheduling an appointment at our office and which could delay the commencement of therapy.

**By checking the box associated with "Informed Consent", you acknowledge that you understand and agree with the following:**

1. I hereby consent to receiving services from Dr. Lowitt's Office via telemedicine technologies. I also understand it is up to Dr. Lowitt's Office to determine whether or not my specific clinical needs are appropriate for a telemedicine encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. These laws also apply to telemedicine. I understand that Dr. Lowitt's Office will take steps to make sure that my health information is not seen by anyone who should not see it, and that no information obtained in my telemedicine consultation which identifies me will be disclosed to other parties, without my consent.

3. I understand there is a risk of technical failures during the telemedicine encounter beyond the control of Dr. Lowitt's Office. I agree to hold harmless Dr. Lowitt's Office and its providers for delays in evaluation or for information lost due to such technical failures.

4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or

treatment. I understand that I may suspend or terminate use of the telemedicine services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that Dr. Lowitt's Office will not be able to connect me directly to any local emergency services.

5. I understand that alternatives to telemedicine consultation, such as in-person services are available to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of Dr. Lowitt's Office (e.g., labs or bloodwork).

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

8. You will not be prescribed opioids for the treatment of pain as a result of the telemedicine consultation.

### **Patient Consent To The Use of Telemedicine**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize healthcare providers from Dr. Lowitt's Office to use telemedicine in the course of my diagnosis and treatment.

*Signature of Patient (or person authorized to sign for patient):* \_\_\_\_\_ *Date:* \_\_\_\_\_, 2020

*If authorized signer, relationship to patient:* \_\_\_\_\_

*Witness:* \_\_\_\_\_ *Date:* \_\_\_\_\_, 2020

I have been offered a copy of this consent form (patient's initials) \_\_\_\_\_