PRIVATE CONTRACT

This agreement is between Dr. Julie Reardon ("Physician"), whose principal place of business is 1313 RR 620 S, Suite 203, Lakeway, Texas 78734, and ____ ("Patient"), who resides at ____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997.

Dr. Julie Reardon has informed Patient that she (Physician) has opted out of the Medicare program effective on October 1, 2013 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical Services to Patient: **Integrative Family Medicine Care**

In exchange for the Services, Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that she/he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit

a Medicare claim for the Services and that no Medicare reimbursement will be provided.

- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.

Executed on _________________ by ____________________________ (print Patient Name) and Julie Reardon M.D.

____
Patient

____
Physician

10/2016

Texas State Board of Medical Examiners

MAILING ADDRESS: P.O. BOX 2018 • AUSTIN TX 78768-2018 PHONE: (512) 305-7010

DISCLOSURE AND CONSENT

Integrative and Complementary Medicine

To The Patient: You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment.

I (we) voluntarily request Dr. Julie Reardon or, under Dr. Julie Reardon's supervision, delegated Nurse Practitioner Theresa Hernandez to treat my health condition which has been explained to me as a desire for improved health using a holistic approach: addressing mind, body and spirit.

I (we) understand that the following integrative and complementary procedure(s) is planned for me and I (we) voluntarily consent and authorize these procedures: active listening with nutritional, supplemental, relaxation, exercise and sleep hygiene recommendations based upon my personal story and medical history and specific laboratory studies that may be ordered.

- I (we) understand that no warranty or guarantee has been made to me as to result of care.
- I (we) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary procedure(s) planned for me.
- I (we) have been given an opportunity to ask questions about my condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.
- I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Name Of Physician Explaining Procedure: Julie Reardon MD or delegate Nurse Practitioner Theresa Hernandez under her supervision
Name Of Person Providing Materials: same

(NOTE: The Texas State Board of Medical Examiners ("Medical Board") adopts this form which may be used by a physician on a voluntary basis to inform a patient, or person authorized to consent for the patient, of the possible risks and hazards involved in the integrative and complementary medical treatment named in the form. The Medical Board recognizes that patients have a right to seek integrative and complementary therapies. However, the use of this form shall not be construed as an endorsement by the Medical Board to practice integrative and complementary medicine and shall not pardon or absolve physicians from disciplinary action that may be taken by the Board.)

Approved at October 15, 1999 TSBME Board meeting. Form Revised 02/19/2019

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information
is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

Practice Policies

Privacy Statement

If you have questions about privacy or how we use your data, please review our HIPAA Consent Form. Lake Travis Integrative Medicine respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing our own internal operations, comply with legal or insurance regulations, or specifically authorized by you.

Communications Security

Secure information/records may be shared via fax. These are submitted directly into Dr. Reardon's electronic medical records platform.

Lake Travis Integrative Medicine does NOT have secure encryption for regular email. Please do not email any private information. See instructions below for emailing through our secure encrypted On Patient electronic medical record.

Patient Communications

All email communications should be submitted via the OnPatient portal. This is the preferred and fastest way to communicate with us.

You may also leave routine messages for our practitioners on our office telephone 512-850-6963. We return phone calls during our regular business hours within 1-2 work days.

If you have an emergency, you should seek immediate help by calling 911 or going to the nearest emergency room. We do not practice acute care and do not have 24-hour coverage. During acute illness, please go to urgent care or an ER to be treated.

Please stay subscribed to our newsletter for notifications about hours and holiday closures.

Permission to Leave Voicemail Messages

The staff of Lake Travis Integrative Medicine has your permission to leave confidential voicemail messages & text messages on the number listed as your primary number in your medical chart. Please ensure that the number you list as your primary number is appropriate for confidential messages or alert our staff of your wishes otherwise.

Prescribing Policies
Texas Law requires that our practitioners see patients on a regular basis in order to prescribe medications. Our office policy is that all patients requesting refills must have been seen in the office within the past six months.

Supplements
It is important to us that our patients understand that they are under no obligation to purchase nutritional supplements from us.

Sourcing high quality supplements for our patients and offering them in the office is a service we offer simply as a convenience to our patients, and they are available to patients only by choice.

Whether supplements are purchased in our office or elsewhere, supplements recommended by our practitioners may consist of vitamins, minerals, amino acids, or herbs and botanicals. These are considered nutritional support and are not intended for treatment of a sickness or disease.

Supplements may not have been reviewed or approved by the US Food and Drug Admin (FDA) or Texas Department of Health (TDH). I also understand that my practitioner may make possible recommendations for dietary supplements based on her understanding of the nutritional, botanical and related scientific literature but that in many areas, the state of this scientific knowledge is incomplete and may be subject to future development, review and possible professional disagreement.

By signing this form, you agree not to hold Lake Travis Integrative Medicine accountable for any claim or responsibility for the results or lack thereof related to taking the above-mentioned supplement products.

Financial Responsibility
Payment is due at the time of service via cash, check, or credit card. Patients are required to keep a valid credit card on file. In order to focus our energy on improving your health and well-being we do not contract with any insurance carriers or Medicare. Medicare patients can see her under private contract; however, Medicare will not reimburse for these visits.

We require 48 hours' notice for a changed or cancelled appointment due to the generous amount of time allotted per visit. Last minute cancellation fees are equal to the charge for the visit. We reserve the right to charge your credit card on file for late cancellations or no-show appointments.

Since Lake Travis Integrative Medicine does not participate in any insurance plans your signature on this form indicates you understand and agree that we do not take assignment. This means that payment will be required at the time of each visit.

Rates
Current rates are posted on our website at all times and are subject to change.

Medicare Patients
Lake Travis Integrative Medicine has opted out as a Medicare provider and does not accept Medicare payment. If you are a Medicare patient and you choose to see us and pay out of pocket, you will not be able to submit charges for reimbursement.

Medical Management Service
There are times when a patient request is not appropriate for a quick Patient Portal response, such as reviewing recommendations from a specialist or making a referral for an issue we don't often address. In these cases, we charge a small fee to cover the practitioner's time. Patients will be notified in advance so that the patient are given the option to make an appointment for an in-office, video or phone review of the issue.

Insurance
If you choose to involve a health insurance company in your care, you assume all responsibility for submitting your own insurance forms. You will be provided with a receipt in order to file a claim with your insurance company if you choose. Most insurance companies have an out-of-network benefit. You may or may not be reimbursed, depending on the benefit package of your insurance plan, although the amount of reimbursement depends upon the specifics of your policy.

Please note if you do provide our superbills to your insurance company for reimbursement of out of network expenses, the company is entitled to request your complete medical records from us.

Labs
Lake Travis Integrative Medicine is considered an "out of network provider" by insurance. Some lab testing may be covered by insurance but is not guaranteed. When possible, we will work to order labs using your insurance. Some labs may be ordered directly through our office at discounted rates. Note: Most specialty labs - such as genomic and microbiome testing - are not covered by insurance at this time.

The normal rate of scheduling for testing is no more than two laboratory's tests per visit. While we respect some patients' preference to schedule all of their specialty testing at once, more than two tests ordered will require additional follow-up appointments for review. Please discuss this with Corrie if you have any questions about follow-up scheduling for lab reviews.

Wellness Services Acknowledgement
Patients who participate in Group Visits, Mind Body Medicine, Wellness Coaching, and other ancillary medical and wellness services do not necessarily create a doctor-patient relationship with Julie Reardon, MD. Specifically, Wellness Services-only patients are not eligible for Medication Management services without having seen the physician or nurse practitioner in a private visit.

Complaints
Please bring any complaints or concerns about your care to Dr. Reardon's personal attention.

Medical Records Release Authorization
By signing below, you authorize us to release your medical information to any physician or health practitioner to whom you are being referred for care, and to any insurance companies or managed care programs you authorize upon their specific request.

Treatment Authorization
By signing below, you are authorizing Julie Reardon M.D. or her delegated practitioners to provide medical and health care treatment for yourself and/or your minor child.

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Acknowledgement
I hereby acknowledge that I have read the above Practice Policies for Julie Reardon, MD, PLLC DBA Lake Travis Integrative Medicine and agree with these important information and guidelines. I have received a copy for my own records.

____ _______________________
Patient Name Date