PATIENT FORM

1 Additional Forms

2 Review & Submit

Additional Forms

Miracle Med Wellness Patient Paperwork

Miracle Med Wellness
DJENSEN MEDICAL

Patient Rights and Responsibilities

You have the right to:

Be treated with dignity, respect and consideration.
Not be discriminated against based on race, age, biological gender, national origin, religion, sexual orientation, disability, marital status or diagnosis.

To receive privacy and treatment and care for personal needs.

To receive treatment that supports and respects your individuality, choices, strengths and abilities.

Not be subjected to misappropriation of personal and private property by your provider or its staff.

To review upon written request your medical record.

Safe care and not be subjected to neglect, exploitation, coercion, Manipulation, abuse (Physical, sexual, emotional) or sexual assault.

Know the identity of those professionals that are treating you.
Participate or have your legally appointed representative participate in the development of or decisions concerning treatment.

To receive a referral to another provider if our clinic cannot provide services needed.

Refuse or withdraw treatment to the extent permitted by law including research or experimental treatment.

Receive explanation prior to any transfer of care.

Have assistance from a family member, representative of other individual in understanding, protecting, or exercising your rights.

File a complaint with a manager, the department of health services, or your provider without retaliation.

Understand why someone is involved or observing care.
Not be restrained or secluded.

Received, on request, information about schedule of rates, charges, explanation of bill, regardless of source of payment.

Consent to photographs before one is taken, except for photos taken for identification/administration purposes.

Have an advance directive concerning treatment.

Except in an emergency, provide you with alternative to a proposed psychotropic medication or surgical procedure along with any associated risks and possible complications of the proposed treatment.

You have the responsibility to:

Provide accurate and complete information concerning present complaints, past medical history, and other matters relating to his or her health.

Make it known whether you clearly comprehend the course of treatment and what is expected of you.

Follow the treatment plan established by your physician including the instructions of nurses and other healthcare professionals as they carry out the physician's orders.

Keep appointments and notify Dr. Jensen when unable to do so.

Accept responsibility of your actions should you refuse treatment or not follow the physician's orders.

Assure that financial obligations of your care or fulfilled as promptly as possible.

Follow AZCCC policy and procedures.

Be considerate of the rights and property of other Patients and facility personnel.

Notify the AZCCC staff of requests for interpretation services.
HIPAA Omnibus Notice of Privacy Practices
Effective Date: 2/21

MIRACLE MED WELLNESS
DJENSEN MEDICAL

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors 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 that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

• Treatment: We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

• Payment: Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

• Health Care Operations: We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

• Minors: Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

• Required by Law: We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

• Abuse, Neglect, and Domestic Violence: Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

• Judicial and Administrative Proceedings: As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

• Law Enforcement: We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

• Coroners and Medical Examiners: We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

• Public Health: Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

• Health Oversight Activities: We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

• Inmates: If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

• Military, National Security, and other Specialized Government Functions: If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

• Immunizations: We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

• Worker's Compensation: We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

• Practice Ownership Change: If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

• Breach Notification Purposes: If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

• Research: Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

• Business Associates: We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

• Communication with family and/or individuals involved in your care or payment of your care: Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

• Disaster: In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

• Fundraising: As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

• Disclosure of Psychotherapy Notes: Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

• Disclosures for marketing purposes and sale of your Protected Health Information

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

• You have the right to inspect and copy your Protected Health Information (reasonable fees may apply): Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

• You have a right to a summary or explanation of your Protected Health Information: You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

• You have the right to obtain an electronic copy of medical records: You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

• You have the right to receive a notice of breach: In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

• You have the right to request Amendments: At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

• You have a right to receive an accounting of certain disclosures: You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

• You have the right to request restrictions of your Protected Health Information: You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

• You have a right to request to receive confidential communications: You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

• You have a right to receive a paper copy of this notice: Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE
We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. We will not retaliate against you for filing a complaint.

COMPLAINTS
If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.

If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

If you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), call 202-619-0257 (toll free 877-696-6775), or mail to:

Secretary of the US – Department of Health and Human Services
200 Independence Ave S.W.
Washington, D.C. 20201

Acknowledgment of Receipt of Notice of Privacy Practice

Noticed to Patient:

We are required to provide you with a copy of our Patient Rights and Responsibilities and Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

I have knowledge that I have received a copy of this office's Notice of Privacy Practices.

Please type your name to sign below | Date: 12/08/2021

☐ I am the parent/guardian of this patient

X

Consent to be treated by Dr. Jensen or other qualified staff
Patient Agreement

This Agreement is entered into on (date):

by and between DJENSEN MEDICAL LLC, and Arizona LLC, NPI number 1174855
Jensen DO, (physician) in his capacity as an agent of DJENSEN MEDICAL LLC, ar

Background
The medical providers of DJENSEN MEDICAL , who specialize in family medicine, delivers care on behalf, via telemedicine. In exchange for certain fees paid by you, DJENSEN MEDICAL, through its medical providers, agrees to provide Patient with the services described in this Agreement on the terms and conditions set forth in this Agreement.
Definitions

1. Patient. A Patient is defined as those persons for whom the medical provider shall provide services, and who are signatories to, or listed on the documents attached as appendix one, and incorporated by reference, to this Agreement.

2. Services. As used in this agreement, the term Services, shall mean a package of services, both medical and nonmedical, and certain amenities (collectively "Services") , which are offered by DJENSEN MEDICAL, and set forth in Appendix 1.

3. Terms. This Agreement shall commence on the date signed by the parties below and shall continue for a period of one month, automatically renewed.

4. Non-participation in insurance. Patient acknowledges that DJENSEN MEDICAL, nor the medical provider participate in any health insurance or HMO plans or panels and has opted out of Medicare. Neither of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third-party payment plans applicable to the Patient. The Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, the Patient will sign the Agreement attached as Appendix 2, and incorporated by reference. This Agreement acknowledges your understanding that the medical provider has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for you by the medical provider. You agree not to bill Medicare or attempt Medicare reimbursement for any such services. Patient shall renew and sign the Agreement in appendix 2.
6. Insurance or other medical coverage. Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any service is not personally provided by DJENSEN MEDICAL, or its medical providers. Patient acknowledges that DJENSEN MEDICAL has advised that Patient obtain or keep in full force such health insurance policies or other plans that will cover Patient for general health care costs. Patient acknowledges this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry.

6. Term; Termination. This Agreement will commence on the first date written above and will extend monthly here after. Notwithstanding the above, both Patient and DJENSEN MEDICAL shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. Unless previously terminated as set forth above, at the expiration of the initial one month term (and each succeeding monthly term), the Agreement will automatically renew for successive monthly terms upon payment of the monthly fee at the end of the contract months.

7. Communications. You acknowledge that communications with a medical provider using email, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communication. As such, you expressly waive the medical providers obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may be part of your medical records. By providing the Patient's email address on the attached Appendix 1, Patient authorizes DJENSEN MEDICAL, and its medical providers to communicate with Patient by email regarding the Patient's protected health information (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and its implementing regulations) By inserting Patient's email address in Exhibit 1, Patient acknowledges that: (a) email is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third-party may gain access; (b) although and the medical provider will make all reasonable efforts to keep email communications confidential and secure, neither DJENSEN MEDICAL, nor the physician can assure or guarantee the absolute confidentialities of email communications; (c) in the discretion of the medical provider, email communications may be made Patient's permanent medical records; and, (d) Patient understands and agrees that email is not an appropriate means of communicating regarding emergency or other time sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or situation in which the member could reasonably expect to develop into an emergency, member should call 911 or the nearest emergency room, and follow the directions of emergency personnel. If the Patient does not receive a response to an email message or phone communication within one day, Patient agrees to use other means of communication to contact the medical provider. Neither DHS and medical, nor the medical provider will be liable to Patient for any loss, cost, injury, or expense, caused by, or resulting from, a delay in responding to the Patient as a result of technical failures, including but not limited to, (i) technical failures attributed to any Internet service provider, (ii) Power outages, failure of any electronic messaging software, or failure to properly address email messages, (iii) Failure of the practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by third-party; or (v) your failure to comply with the guidelines regarding use of email communications set forth in this paragraph.

8. Change of Law. If there is any change of law, regulation or rule, federal, state or local, which affects the Agreement including these Terms & Conditions, which are incorporated by reference in the Agreement, or activities of either party under the Agreement or any change in judicial or administrative interpretation by any such laws, regulations or rules, and either party reasonably believes in good faith at the changes will have a substantial adverse effect on that parties rights, obligations or operations associate it with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement including these Terms & Conditions. If the parties are unable to reach an agreement concerning the modification of the Agreement within 45 days after the date of the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.

9. Severability. If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any Jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make a provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

10. Reimbursement for services rendered. If this Agreement is held to be invalid for any reason, and if DJENSEN MEDICAL is therefore required to refund all or any portion of the monthly fees paid by the Patient, Patient agrees to pay DJENSEN MEDICAL an amount equal to the reasonable value of the services actually rendered to the Patient during the period of time for which the refunded fees were paid.

11. Amendment. No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all parties. Notwithstanding the foregoing, the medical provider may unilaterally amend this agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending you 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by DJENSEN MEDICAL, except the Patient shall initial any such change a DJENSEN MEDICAL's request. Moreover, if applicable law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provision shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.
13. Assignment. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by the Patient.

12. Relationship of parties. Patient and the medical provider intend and agree that the medical provider, in performing his or her duties under this Agreement, is an independent

contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the medical provider shall have exclusive control of his/her work and the manner in which it is performed.

13. Legal Significance. Patient acknowledges this Agreement is a legal document and creates certain rights and responsibilities. Patient acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the Terms & Conditions of the Agreement.

14. Miscellaneous. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for the convenience only and shall not limit, broaden, or qualify the text.

15. Entire Agreement. This Agreement contains the entire agreement between the parties and supersedes all prior oral and written understandings and Agreements regarding the subject matter of this Agreement.

16. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Arizona (or any other state for which the provider is legally practicing) and all disputes arising out of this Agreement shall first be disputed by arbitration and if unsuccessful arbitration attempts have not resolve the dispute that settled in the court of proper venue and jurisdiction for DJENSEN MEDICAL address in Peoria Arizona.

17. Service. All written notices are deemed served if sent to the address of the party written above by first class U.S. mail. The parties have signed duplicate counterparts of this Agreement on the date first written above. DJENSEN MEDICAL.

18. Cancellation Policy: Cancellations must be notified 24 hours before appointment. "No shows" will be subject to a $50 charge. Charge will be processed with credit card on file. To cancel via email, state in subject line "Cancellation" with date of appointment and last name. Example: "Cancellation 1/1/21 Jensen". You also have the option to call and cancel your appointment.

19.Patient must be located in Arizona or Utah.

Please type your name to sign below | Date: 12/08/2021

☐ I am the parent/guardian of this patient

X ______________________ 12/08/2021

19. Fees. For For patients doing the monthly subscription, in exchange for the medical services described
herein, Patient agrees to pay DJENSEN MEDICAL, the amount of $150 per Patient encounter **unless otherwise specified** with subscription model of $100 monthly plus applicable processing fees, or other arrangement in writing. This fee or any other is payable upon execution of this Agreement, and is in payment for the services provided to the Patient during the term of this Agreement. This amount is subject to change. If this Agreement is canceled by DJENSEN MEDICAL before the Agreement termination date, then DJENSEN MEDICAL shall refund the Patients prorated share of the original payment, remaining after deducting individual charges for services rendered to the Patient upon cancellation.

You are not signing up for concierge medicine (monthly subscription) **unless you sign here** and are approved by the doctor. **The doctor will make the final determination if you will become a concierge patient and will discuss it with you at the time of the appointment.** Concierge patients have access to Covid treatment and Covid protocols.

People seeking Covid treatment and Covid prevention are not automatically enrolled in concierge services. Concierge services are only determined by the doctor and discussed with the patient at time of appointment. Due to demand, follow up Covid treatment and Prevention are $75 effective 11/17/21

Please type your name to sign below | Date: 12/08/2021

☐ I am the parent/guardian of this patient

X ______________________ 12/08/2021

Appendix 1
Services and Payment Terms

(This signature is required for all, if you are not a Medicare recipient this will have no effect on you however we have to require it be signed by all so it is not missed by those who are Medicare recipients.)

1. Medical services. As used in this Agreement, the term Medical Services shall mean those medical services that the physician, himself or herself is permitted to perform under the laws of the state of Arizona and that are consistent with his/her training and experience as a family medicine physician, as the case may be. Patient shall request to be entitled once every 365 days to an annual in-depth "wellness examination and evaluation," which shall be performed by the physician, and include the following: Health Risk Assessment, Comprehensive Lab Screening, Psychosocial Screening. Custom Wellness Plan to include general exercise and dietary plan. *Some restrictions apply. The Physician or provider may from time to time, due to vacations, sick days, and other similar situation, not be available to provide the service is referred to above in this paragraph 1. During such times, Patient calls to the physician, or the physicians office, will be directed to a provider who is "covering" For the physician during his or her absence. DJENSEN MEDICAL will make every effort to arrange for coverage but cannot guarantee such coverage.

2. Non-Medical. Personalize services. DJENSEN MEDICAL shall provide Patient with the following non-medical services ("Non-Medical Services"): (a) Monday-Friday 8:00-5:00 Arizona time access (excluding federal holidays). Patient shall have access to the physician via instant messaging, text messaging and or video chat. Patient shall also have direct telephone access to the Physician during normal business hours Monday through Friday. Patient shall be given phone number where Patient may reach the Physician directly during these business hours. After hours coverage may be provided but not guaranteed and is subject to additional fees. During the Physicians absence for vacations, continuing medical education, illness, emergencies, or days off, DJENSEN MEDICAL will provide the services of an appropriate licensed healthcare provider for assistance in obtaining medical services. Patient shall be given instructions as to how to contact such healthcare provider. Such provider shall be available to Patient to the same extent as would the physician, however provider shall be contracted through an answering service rather than through a direct phone line. (b) E-Mail Access. Patient shall be given the physicians email address to which non-urgent communications can be addressed. Such communications shall be dealt with by the physician or staff member of the practice in a timely manner. Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that the Patient can reasonably expect or may develop into an emergency. Patient agrees that in such situation, when Patient cannot speak to Physician immediately in person or by telephone, that Patient shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency Medical personnel. (c) Timely services. Every effort shall be made to ensure the Patient is seen by the Physician on the same day when possible or within 24 hours during normal business hours of operation. If Physician can foresee deviations from this every effort will be made to inform the Patient of projected wait times. (d) Same Day/Next Day Appointments. When Patient calls or emails the Physician prior to noon on a normal office day (Monday through Friday) to Schedule an appointment, every reasonable effort shall be made to schedule Patient appointment with the Physician on the following normal office day. In any event, however, DJENSEN MEDICAL shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made. (e) Home or Office Visits. Patient may request that the Physician see the Patient in Patient's home or office for an additional fee that is subject to change and prepaid to the provider. The provider reserves the right to deny such requests. (f) Specialists. DJENSEN MEDICAL Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. Patient understands that fees paid under this Agreement do not include and do not cover specialist fees or fees due to any medical professional other than the DJENSEN MEDICAL physician.

Appendix 2 - Applies only to Medicare Beneficiaries
vii.

Contract for Services Provided to Medicare Beneficiaries This Agreement is between DJENSEN MEDICAL, (NPI - 1174855859) and ("Beneficiary")

who resides at

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B. (a) Physician has informed Beneficiary that Physician has opted out of the Medicare Part B with respect to services offered by DJENSEN MEDICAL for a period of at least two years. (b) Physician is not excluded from participating in Medicare Part B under Sections 1128,115, or 1892 or any other section of the Social Security Act. (c) Beneficiary or his or her legal representative accepts full responsibility for payment of Physician's charge for all services furnished by Physician, including applicable taxes on such services. (d) Beneficiary or his or her legal representative understands that Medicare limits do not apply to what Physician may charge for items or services furnished by Physician. (e) Beneficiary or his or her legal representative agrees not to submit a claim to Medicare or to ask Physician to submit a claim to Medicare. (f) Beneficiary or his or her legal representative understand that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim has been submitted. (g) Beneficiary or his legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that Beneficiary 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.

(h) The effective date of Physician's opt-out of Medicare is

and the opt-out period is anticipated to be indefinite. (i) Beneficiary or his or her legal representative understands that the Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. (j) This contract was not entered into by Beneficiary or by Beneficiary's legal representative during a time when Beneficiary requires emergency care services or urgent care services. (k) Physician has provided a photocopy or digital copy of this Contract to Beneficiary or to his or her legal representative before items or services were furnished to Beneficiary under the terms of this contract.

I have read and agree to all provisions of the above Contract. "Beneficiary"

Please type your name to sign below | Date: 12/08/2021

☐ I am the parent/guardian of this patient

X ______________________ 12/08/2021

Providing us with authorization to email and text you will allow DJENSEN MEDICAL to exchange information with you more efficiently and will benefit you as a member. At the same time, we recognize that email and text messaging are not a completely secure means of communication.

You are not required to authorize the use of email and text messages and a decision to not authorized electronic communication will not affect your health care in any way.
We have taken considerable effort to protect the personal health information of our members, and recommend that all members provide us with this authorization that we can more efficiently communicate with them.

Email:

Cellular Number:

Authorization to Release Information
This authorization is for the use or disclosure of health information pertaining to:

Patient's Full Name: (optional)

Date of Birth: (optional)

I, (optional)

hereby authorize the clinical staff of Dr. David Jensen, Djensen Medical or Miracle Med Wellness, to release clinical records and information above name patient's health history, treatment, and services to:

Name: (optional)

Address: (optional)

City: (optional)

State: (optional)

Zip: (optional)

Phone: (optional)

Fax Number: (optional)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective immediately to the extent that our office has taken action in reliance of the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer as a legal right to contest the claim.
I understand that Dr. David Jensen, Djensen Medical or Miracle Med Wellness may not condition my receiving health services upon signing an authorization, unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Unless otherwise specified, this authorization is expires in one year.

Please type your name to sign below | Date: 12/08/2021

☐ I am the parent/guardian of this patient

X ______________________ 12/08/2021

If authorization is signed by a personal representative or guardian of the patient, a description of such representative's authority to act for the patient must be provided (relationship to Patient). (optional)

NEXT