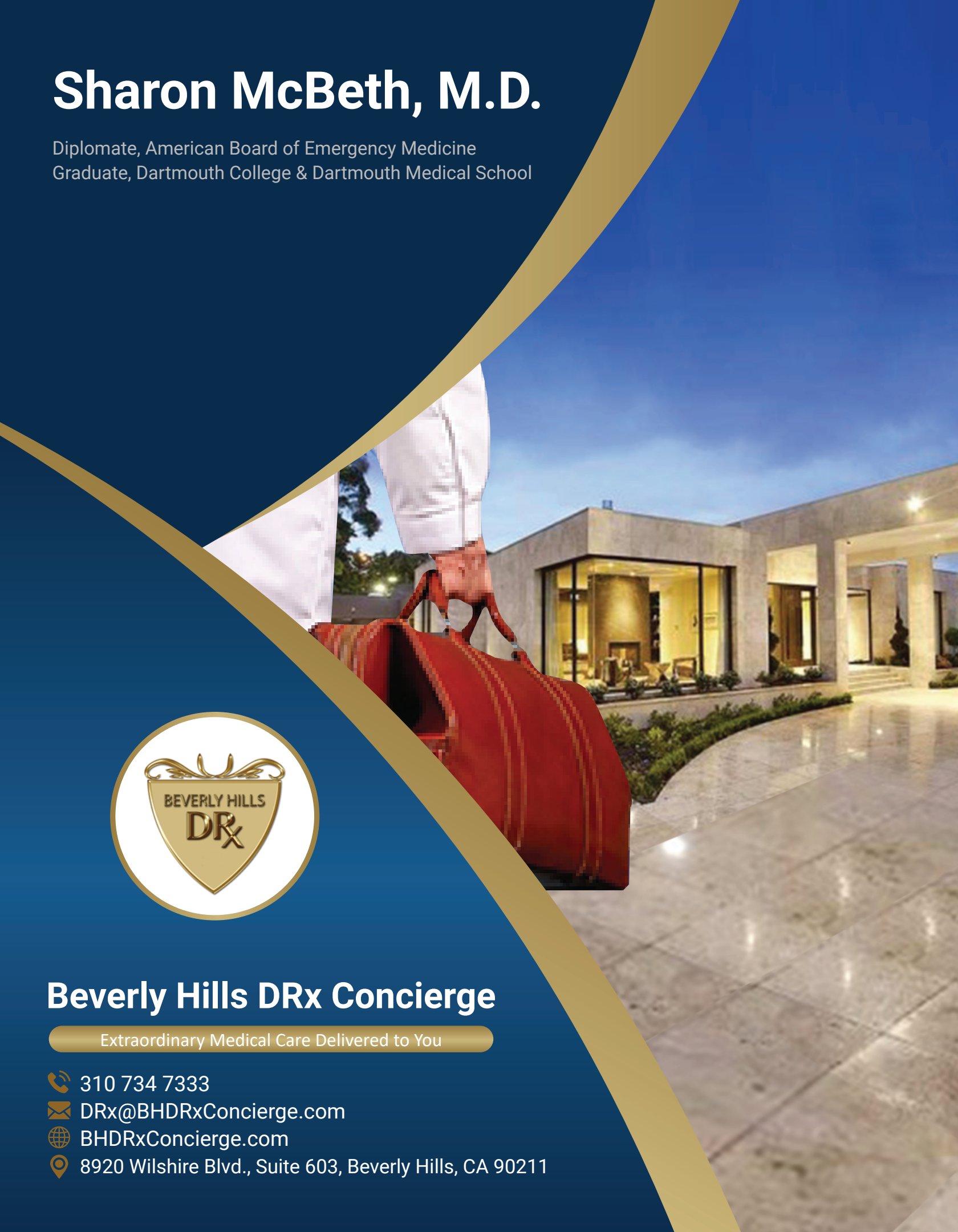
Sharon McBeth, M.D.

Diplomate, American Board of Emergency Medicine
Graduate, Dartmouth College & Dartmouth Medical School



Beverly Hills DRx Concierge

Extraordinary Medical Care Delivered to You

310 734 7333
DRx@BHDRxConcierge.com
BHDRxConcierge.com
8920 Wilshire Blvd., Suite 603, Beverly Hills, CA 90211

Financial Disclosures

Patient's Name:

Date of Service:

This is a legally binding contract between Beverly Hills Drx Concierge, Sharon McBeth, M.D. and the patient and/or guardian. The words, I, me, my, you, and your all, refer to the patient. By signing below, I understand and agree to the following:

(a) CONSENT & RELEASE:

I consent to evaluation and treatment as proposed and understand that this medicalservice does not necessarily constitute total possible care. I hereby release the above mentioned of any responsibility for medical services provided or recommended.

(b) AGREEMENT TO COMPLY

I agree to reasonably comply with the treatment and/or follow-up care as recommended by my physician, and to notify Dr. Sharon McBeth, if I am unwilling to comply with this recommended treatment or additional care. I agree to release and hold harmless my treating physician & Beverly Hills DRx Concierge for any complications or adverse consequences arising from this failure to comply.

(c) FINANCIAL AGREEMENT **Visa** **MC** **AMEX**

Last 4 digits of Credit Card **Exp** **/**

By signing this agreement, you understand and agree that if you have insurance, **Beverly Hills DRx Concierge or Sharon McBeth, M.D. does not submit or bill your insurance directly.** You understand and agree that you must pay **Beverly Hills DRx Concierge or Sharon McBeth, M.D.** for your medical services performed today and that **Beverly Hills DRx** Concierge will provide you an insurance claim form that you may submit to your insurance for reimbursement. By signing this agreement, you understand and agree that this contract constitutes as a valid authorization for you or your party's credit card for full payment at the time of service for all medical costs. This includes but, is not limited to travel expenses, consultation fees, telemedicine consultation fees, emergent service fees, after hours fees, procedures, laboratory based, diagnostic tests, X-rays, ultrasounds, urine tests, bedside diagnostic tests, injections, medications, IV Fluids, minor surgeries, physical therapy, manual osteopathic manipulation, foreign body removal, ear treatments, eye treatments, joint injections, neck , back, musculoskeletal treatments, travel documentation, and medication dispensing fees. If payment is unable to be credited at time of visit, you authorize your credit card(s) to be charged weekly and/or monthly until balance of payment is made. By signing this agreement, you understand and agree that service fees are subject to change based on the time of day, holiday or weekend, individual physician treating, time spent with patient, and time spent to arrive to patient. By signing this agreement, you understand and agree that if the treating physician determines that you must go to the emergency room for further treatment and/or tests, you are still responsible for the consultation and treatment rendered. By signing this agreement, you understand and agree that regardless of any insurance coverage you may have, you are responsible for payment of your account. You understand and agree that delinquent accounts will be referred to a collection service. If it becomes necessary to send your account to a collection service, you agree to pay for all costs and expenses, including reasonable attorney fees. You also acknowledge that you have received a copy of this financial agreement for your records

AGREEMENT TO SHARE MEDICAL INFORMATION

(d) I agree that the personal and medical information supplied to me is full and complete to my best knowledge, and that this information is to be solely used for purposes of my medical treatment, and for coordination and payment for the same. I further consent to the request for, and release of, medical information from and to any parties that may be involved in providing medical care to me, and in the payment of all fees charged for services, procedures, labs, medication, etc., and/or releasing medical information, according to law.

I authorize and agree to the above Agreements:

Patient or Guardian Signature:

I decline to authorize release of medical information.

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CONSENT TO USE TELEMEDICINE

Telemedicine Patient's Name:

My Doctor's Name - Sharon McBeth, M.D.

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional inperson consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment, and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record OR No part of the encounter will be recorded without my written consent.

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my credit card details that I provide, by Dr. Sharon McBeth using SOCALHOTELDOCTORS.COM dba Aesthetique Laser Institute, Inc. I have read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

Date: Patient Signature

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HIPAA AUTHORIZATION FORM

1. I hereby authorize use of protected health information about me as described below. The following person/class of person/facility is authorized to use or disclose information about me: Sharon McBeth, M. D. or Beverly Hills DRx Concierge. The following person may receive disclosure of protected health information about me:

2. Name: _____

Address: _____

3. The specific information that should be disclosed: ☐ (check) All information

Or specify: _____

Unless you sign here, no information about alcohol, substance abuse, HIV/AIDS, or mental health will be disclosed:

Yes, disclose this information (signature) _____

No, do not disclose (signature) _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulation.

5. I may revoke this authorization by notifying Beverly Hills Drx Concierge or Sharon McBeth, MD, in writing of my desire to revoke it. However, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on ____ / ____ / ____ OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

Signature: _____ Date: _____

Or, if applicable: Signature Guardian _____

Date: _____

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