Consent to Treat

I, the undersigned parent or legal guardian, hereby give my consent for the physicians, nurses, medical assistants, and other healthcare professionals at Sapphire Pediatrics to evaluate, diagnose, and provide routine medical care and treatment to my child on an outpatient basis.

This consent includes, but is not limited to:

- Physical examinations
- Preventive care and well-child visits
- Administration of medications as prescribed
- Immunizations (with separate vaccine information provided when required)
- Laboratory tests and diagnostic procedures
- Treatment of minor illnesses and injuries

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made regarding the results of treatment.

I authorize Sapphire Pediatrics to release my child's medical information as permitted by law for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received or have access to the clinic's Notice of Privacy Practices.

I understand that I am financially responsible for charges not covered by insurance, including copayments, deductibles, and non-covered services.

I certify that I am the parent or legal guardian of the above-named child and that I have the legal authority to consent to treatment. I have read and understand this consent, and all my questions have been answered to my satisfaction.

No Show and Late Policy

To ensure timely, high-quality care for all patients and families, Sapphire Pediatrics requires advance notice for appointment changes and punctual arrival for scheduled visits.

Appointment Reminders
As a courtesy, appointment reminders may be sent by phone call, text, or email. Receiving a reminder is not required for the appointment to remain scheduled, and it is the parent or guardian's responsibility to attend or cancel as needed.

Late Arrival Policy
We ask patients to arrive at least 15 minutes prior to their scheduled appointment time. This allows us to get you checked in at the front desk and with the medical assistant, so you are ready for your visit with the physician at your scheduled appointment time.
If you arrive more than 10 minutes late, we may have to reschedule your appointment, depending on the availability of the provider and appointment type.
Arriving late may limit the services that can be provided during the visit.

No Show Policy
A no show is defined as a failure to arrive for a scheduled appointment and / or contacting the clinic to cancel or reschedule your appointment at least 24 hours prior to your scheduled appointment.
A fee of $50 may be charged for missed appointments not cancelled within the required time frame. This fee is not typically covered by insurance and is the responsibility of the parent or guardian.

Repeated Missed Appointments
After 3 no shows within one (1) calendar year, you may be dismissed from the practice.

How to Cancel or Reschedule
To cancel or reschedule an appointment, please contact us by phone or through the patient portal during the business hours of 9 am through 5 pm. You are also able to cancel or reschedule your appointments through the patient portal.

HIPAA PRIVACY ACKNOWLEDGMENT & CONSENT

I acknowledge that I have received, reviewed, or been offered a copy of Sapphire Pediatrics Notice of Privacy Practices, which explains how my child's protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
I understand that the Notice describes:

- How medical information about my child may be used and shared
- My rights regarding access, amendment, and restriction of my child's health information
- The clinic's legal duties to protect my child's health information

Consent for Use and Disclosure of Protected Health Information
I consent to Sapphire Pediatrics using and disclosing my child's protected health information as necessary for:

- Treatment (coordination of care among healthcare providers)
- Payment (billing, insurance claims, eligibility verification)
- Healthcare operations (quality improvement, staff training, administrative activities)

I understand that this consent is voluntary and that I may revoke it in writing at any time, except to the extent that action has already been taken in reliance on this consent.

I certify that I am the parent or legal guardian of the above-named child and have the legal authority to make healthcare decisions on their behalf. I have read and understand this HIPAA acknowledgment and consent.

Financial Policy

We believe that in the interest of good health care practices, it is best to establish a patient account policy between our patients and ourselves in order to avoid any misunderstandings. Our front office coordinators will be glad to discuss your account with you at any time. We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility.

Commercial Insurance Payment:
We will bill your insurance for today's service however you will be responsible for any copay, coinsurance, and / or deductible due at the time of service. In addition, your insurance must be verified in advance of the visit. If we are not able to verify your insurance, you will be required to pay for the visit in full at the time of service. Please be prepared to show your insurance card and driver's license at your appointment. We will provide you a receipt to submit to your insurance company.

Insurance Coverage:
Sapphire Pediatrics makes a reasonable effort to know which insurances are in and out of network, as well as which are covered services or not, it is ultimately the responsibility of the patient. It is recommended that you check with your insurance to make sure we are in network, and that any services recommended or received are covered under your benefits.

Newborn Insurance Coverage:
As a courtesy, we will hold all claims for services received for your newborn for thirty (30) days to allow you time to add your newborn(s) to your insurance coverage. After 30 days, we will bill your insurance for all services rendered. If your child(ren) are not eligible for coverage after 30 days, you will be billed as a self-pay patient and be responsible for all charges.

3rd Party:
We do not file any insurance with your Automobile Insurance Company, or any other third party, (insurance company, employer, attorney, separated spouses, etc.) for purposes of obtaining payment. We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties such as a claim form, a statement, or a report. We do not accept Letters of Guarantee or other promises to pay.

Self-Pay Patients:
Sapphire Pediatrics requires a $150.00 time of service downpayment at every visit payable at check in.

Self-Pay Patients are defined as follows:
Those patients without insurance coverage.
Those patients with insurance, but who are considered "out of network", and do not wish to bill for out of network benefits.
Those patients with commercial insurance but choose not to file a claim.
*You must notify the office staff as to your status prior to your visit.
**Patients who have a government sponsored health plan, such as Medicaid or Tricare, are not eligible for self-pay.

Forms of Payment:
We accept cash, check, Debit/Check Card, MasterCard, Visa, and American Express. We also accept FSA, HSA, and other similar accounts. If you are unable to meet your financial obligation at the time of service, we offer a payment plan option for specific situations.

Credit Card on File:
Sapphire Pediatrics requires all patients, with the exception of patients with government sponsored insurance (Medicaid and Tricare), to have a credit card, debit card, FSA, or HSA card on file with our practice. We need to be sure that patient balances are paid in a timely manner and to guarantee payment for services rendered.

Payment Balances and Payment Plans:
Balances are the responsibility of the guarantor on the account. We will file claims with your insurance company, any portion that is due from the patient will be billed and the credit card on file will be charged. "Self Pay" patients are expected to pay any balances and the time of service downpayment at the time of service, except when special arrangements have been made with the billing company.
For patients with difficulty paying their balances, we offer payment plans. Contact the billing office to make arrangements. If balances exceed $500 and regular payments are not made, you may be discharged from the practice.

Missed Appointments:
We ask you give at least 24 hours notice when cancelling appointments. For appointments missed without prior notification, a fee of $50.00 will be applied to each occurrence, starting with the second occurrence. After the third occurrence, the account will be reviewed for dismissal from the practice.

Credit Card On File Authorization

Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is swiped into the ePay system for the first time.

Until further notice, I authorize Sapphire Pediatrics to charge the patient-responsible balances on my account, including old balances, co-pays, co-insurance, deductibles, and non-covered services, to the credit card I swipe into the ePay system.

I understand that I must keep this card information current in this office. Cards denying could incur additional fees.

I understand that once my insurance has paid their portion for the medical care received at Sapphire Pediatrics, the remaining balance is my responsibility as shown on my Explanation of Benefits (EOB) from my insurance company.

I understand that Sapphire Pediatrics will charge my payment card on file for the balance due once the EOB is received. If any balance is $500 or greater, you will receive a courtesy phone call before your credit card is charged.

If I am a self-pay patient, my card will be charged at the time of service.

This payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have questions about this payment method, do not hesitate to ask.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2026

We are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we maintain a physical delivery site, we will also post a copy at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment.** We may use or disclose health information to obtain payment for health care services. For example, we may disclose your health information to your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.

▪ **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
▪ **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice and we may use it for any lawful purpose.
▪ **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
▪ **For Reminders.** We may use or disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.
We may use or disclose your health information for the following purposes under limited circumstances:
▪ **As Required by Law.** We may disclose information when required to do so by law.
▪ **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
▪ **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
▪ **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
▪ **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
▪ **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

▪ **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

▪ **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

▪ **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

▪ **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.

▪ **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

▪ **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

▪ **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

▪ **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and permitted by law.

▪ **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

1. Alcohol and Substance Abuse
2. Biometric Information
3. Child or Adult Abuse or Neglect, including Sexual Assault
4. Communicable Diseases;

5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.
Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled “Exercising Your Rights.”

What Are Your Rights
The following are your rights with respect to your health information:
▪ **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
▪ **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.
▪ **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In

certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

▪ **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies. 8

▪ **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

▪ **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

▪ **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice by calling 1-720-941-1778.

Exercising Your Rights

• **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call 1-720-941-1778**.**

• **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

Sapphire Pediatrics
Attn: Medical Records Department
4500 E. 9th Ave.
Suite 300
Denver, CO 80220

• **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.