OnCall Medical, LLC

Private Pay Agreement/Patient Service Agreement

DO NOT USE OUR APPLICATION TO SEEK MEDICAL SERVICES FOR SOMEONE WHO IS UNCONSCIOUS, NOT BREATHING OR GASPING FOR AIR, HAVING CHEST PAIN, UNCONTROLLABLY BLEEDING, OR ANY OTHER SYMPTOMS THAT REQUIRE IMMEDIATE OR EMERGENT MEDICAL ATTENTION. CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER) IMMEDIATELY IF YOU HAVE AN EMERGENCY MEDICAL NEED.

Note: You need to make a choice about receiving these health care services. The purpose of this form is to help you make an informed decision about whether or not you want to receive the telemedicine/phone consultation service/home visits, knowing that you will have to pay for it yourself.

OnCall Medical, LLC, and its affiliates, predecessors, successors, licensors, and/or beneficiaries (collectively, "OnCall Medical," "we," "us" or "our") welcome you to download our proprietary software currently called "OnCall Medical" (the "Application"). By downloading and using the Application, and by receiving services through the Application and/or via our Website (where applicable) (the "Medical Services") and/or by receiving a referral for Medical Services, you agree to be bound by the terms of service set out below (the "Agreement"). If you disclose to us any information relating to receiving a referral for Medical Services for other people in connection with the Application or Website, you represent that you have the authority to do so and to permit us to use such information in accordance with the Agreement.

Please read the Agreement carefully before accessing or using the Application. If you do not agree to all of the terms of this Agreement, do not use the Application or the Medical Services. OnCall Medical may revise and update this Agreement at any time. Your continued use of the Application will mean you accept the revised or updated Agreement. All references to the "Application" in this Agreement shall be construed to also include our Website (where applicable).

Privacy Policy

Effective as of May 2020

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 will let you know promptly if a breach occurs that may have compromised the privacy or security of your protected health information. 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.

Ways We May Use and Disclose Your Protected Health Information Without Your Authorization

Your protected health information may be used and disclosed by your clinician, our office staff and others 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 our practice. The following are examples of the types of uses and disclosures of your protected health information that we are 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.
Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our 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. For example, we use health information about you to manage your treatment and services and to contact you about appointments or test results.

Other Permitted or 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:

Disclosures to Business Associates: We may 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 must have a written contract that contains terms that will protect the privacy and security of your protected health information.
Treatment Alternatives and Health-Related Benefits and Services: 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.
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 or required 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 certain 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, including (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures of your protected health information for marketing purposes, unless an exception applies; and (3) disclosures that constitute the sale of your protected health information. 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 pursuant to your authorization and prior to receiving your revocation.

Your Rights

The following is a description of your rights with respect to your protected health information and a brief description of how you may exercise these rights. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your protected health information. We will make sure the person has this authority and can act for you before we take any action.

Right to Access. You have the right to inspect and copy your protected health information, with the exception of psychotherapy notes and under certain circumstances such as information compiled in anticipation of litigation or if providing you with such access will endanger your life or physical safety. You may obtain your medical record that contains medical and billing records and any other records that we use to make decisions about you. To the extent feasible, access or a copy of your medical information will be provided to you in the form or format that you request, including an electronic form or format if we maintain your medical information electronically. As permitted by federal or state law, we may charge you a reasonable fee for a copy of your records.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical information because of a threat or harm issue, you may request that the denial be reviewed. Another licensed clinician chosen by Dispatch Health will review your request and the denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Please contact us directly at **info@oncallmedical.net** if you have questions about obtaining access to or inspecting your medical record.
Right to Request a Restriction. 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. To request a restriction, you must submit your request in writing to **info@oncallmedical.net** for further information We are not required to agree to your request, except if you have paid for services out-of-pocket in full and ask us not to disclose your protected health information related solely to those services to your health plan for payment or health care operations purposes. If we 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 clinician.

Right to Request Confidential Communications. 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 **info@oncallmedical.net**.

Right to Request an Amendment. You have the right to request that we amend your protected health information, for so long as we maintain this information, if you feel that the information we have about you is incorrect or incomplete. You must provide a reason to support your request for an amendment. We may deny your request if it is not in writing or if it does not include a reason supporting the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Dispatch Health;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

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 us at **info@oncallmedical.net** if you have questions about amending your medical record.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information for the six (6) years prior to your request for the accounting. 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 may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting you may be charged a fee. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Obtain a Copy of this Notice. 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.

This Patient Service Agreement is entered into between OnCall Medical, LLC ("OCM") and the undersigned patient ("Patient") for access to the services defined herein (the "Agreement"). OCM and Patient shall hereinafter be referred to as individually the "Party" and collectively as the "Parties".

ONCALL MEDICAL SERVICE

- OCM is a professional medical services entity that provides in-home as well as telehealth services that enables its patients to access and consult with a licensed professional via OCM's proprietary system, methods and protocols. As a patient you will have limited access to certain services, including, but not limited to, phone call, telemedicine and at-home consultations.
- Professional Services. Patient will have access to professional medical services from licensed physicians or supervised physician assistants and/or nurse practitioners ("Professionals") via telemedicine (when deemed safe and appropriate by Provider and other applications ("Professional Services").
- Patient acknowledges and understands that he or she will not receive any services from OCM or its Professionals unless defined as a Service or Professional Service under this Agreement or OCM policy. Patient acknowledges and understands that OCM and its Professionals are engaged for limited purposes and are not his or her primary care or specialized practitioner.
- OCM and its Professionals may prescribe medicines or other treatments, procedures, services or products to Patient in connection with Patient's treatment; however, to the extent that such prescriptions or other treatments, procedures, services or products are discussed by the Professionals, neither OCM (to the extent applicable), nor the Professionals shall be deemed to be making claims, express or implied, as to the efficacy for any medical condition. Patient shall contact a primary care physician or specialist regarding any issues that may be identified or arise during receipt of Services and Professional Services pursuant to this Agreement.
- Patient acknowledges and understands that the scope and delivery of the OCM Services set forth in this Section may be amended or modified at any time at the sole discretion of OCM.

OnCall Medical, LLC

BILLING AND PAYMENT

- Fees for Service. Each Patient shall be responsible for and agrees to pay a (USD) fee at completion of services as rendered. The Fee shall cover all costs and expenses owed by Patient for access to and receipt of Services as defined in Section 1.1 herein.
- Patient understands and agrees that the Fee shall be paid at the time of completing the payment forms available online (oncallmedical.net). The fee will be a one-time payment per transaction.
- If the Fee is not paid in full by the fifteenth (15th) day of each month, except if due to an error or failure by OCM or its representatives, Patient may be subject to a late charge of $5.00 (USD) per visit and interest thereafter at the rate of one and one-half percent (1.5%) per month on the outstanding balance, or the highest amount permitted by law, whichever is lower.
- Professional Fee. Patient shall be responsible for and agrees to pay the costs of Professional Services received during this Agreement by Patient based on timed increments and billed on a one-time basis from the date that Patient receives treatment ("Professional Fee"). The Professional Fee shall be at the discretion of OCM based on the amount of time required of the Professional plus a proportionate amount of OCM's total overhead costs to provide the Professional Service. The then current Professional Fees shall be available for reference online (www.oncallmedical.net) or by emailing (**info@oncallmedical.net**).
- OCM may, but is not required to, offer discounted fees or similar incentives to Patient from time-to-time depending on financial hardship, without changing the Patient's liability for the fees incurred hereunder, it being explicitly agreed that OCM is under no obligation to extend such other discounted fees or incentives to Patient. OCM has sole discretion as to who receives discounts, the amounts of discounts, when discounts are issued and all other issues related to the issuance of discounts.
- The fee amounts in this Section may change at any time pursuant to an amendment to this Agreement at the sole discretion of OCM for any reason. OCM is not required to provide online notice of such change at any time.
- Patient understands that the fees in this Section do not include the costs of any prescription medicines or other treatment, procedure, service or product provided by separate independent entities or individuals that may be prescribed or recommended by OCM and its Professionals in connection with the Patient's treatment. Patient understands that he or she may receive one or more separate bills for such prescription medicines and other treatments, procedures, services or products and is wholly responsible for payment of such costs, and further understands, that the independent entities and individuals will have their own billing and collection practices.

INSURANCE DISCLAIMER

- Patient represents and warrants that the OCM Services to be provided pursuant to this Agreement are not covered under any public or private health insurance program. Notwithstanding the above, Patient understands and agrees to be wholly responsible for the payment of any and all costs due and that may become due pursuant to this Agreement, regardless of the existence of coverage for such items or services under any public or private health insurance program.
    - Patient understands and agrees not to submit a claim, bill to or seek reimbursement from any public health program (i.e. Medicare, Medicaid, Tricare, Veterans Affairs and Federal Benefits) or any private health insurance plan or worker's compensation plan for any item or service received pursuant to this Agreement. Patient understands that he or she will not be able to appeal any determinations that public health program, private health insurance plan, or worker's compensation plan will not pay for any item or service received pursuant to this Agreement.

Patient Responsibilities

- Patient understands that it is the Patient's responsibility to gain access to a telephone, computer, email, the internet or video conferencing service to facilitate the provision of OCM's Services under this Agreement.
- Patient understands that it is the Patient's responsibility to provide OCM and its Professionals with accurate and complete medical records, history and descriptions of the Patient or covered family member's condition and physical well-being. Patient understands that, as with any service, to the extent that information provided is not accurate and complete, the services provided by OCM and its Professionals may be materially affected and Patient assumes any risk, and takes full responsibility and waives any claims against OCM and its Professionals for personal injury, death or damages as a result and agrees to the extent permitted by applicable law to defend, indemnify and hold harmless OCM and its Professionals from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from inaccurate or incomplete information provided by Patient or its authorized representative.

- Patient understands that he or she is responsible for requesting and bearing the costs of copying any medical records necessary for OCM and its Professionals to provide services under this Agreement as set forth in Terms of Use.

MISCELLANEOUS

- Patient Consent. If Patient is unable to sign, consent for treatment is given by his or her duly authorized representative. For purposes of this agreement, the term "Patient" includes any representative(s) of Patient authorized to make decisions and sign this Agreement on the Patient's behalf.
- Notice of Privacy Practices. Patient acknowledges having access to and reviewed OCM's Notice of Medical Information Privacy Practices, which provides information about how OCM and its Professionals may use and disclose the Patient's protected health information. The Notice of Medical Information Privacy Practices may be subject to change. If you have any questions about our Notice of Medical Information Privacy Practices, please contact a designated representative.
- Assignment. Patient shall not assign this Agreement, nor its right, title or interest herein assigned, transferred, conveyed, sublet or otherwise disposed of without the express written consent of OCM and any attempts to assign this Agreement without written consent are null and void. OCM will not necessarily be the provider of services under this Agreement and Patient may be provided services under this Agreement by a contracted professional medical individual or entity. Patient agrees that OCM may delegate responsibilities related to the OCM's Services to one or more independent contractors.
- Third Party Software. OCM does not warrant any software created or licensed in connection with the EHR Patient Portal ("Third Party Software"). Warranties with respect to Third Party Software are subject to such limits and conditions as are contained in the license agreements for the Third Party Software. Patient will be considered to have accepted the license agreements for the Third Party Software upon execution of this Agreement. Patient agrees that the Third Party Software is a documentation tool only, and that the Third Party Software is not intended to provide diagnoses, practice guidelines, advice or protocols for delivering medical care. Patient further agrees that it shall be solely responsible to ensure that the documentation of medical care is accurate. Under no circumstances shall OCM shall have any responsibility or liability as a result of this Agreement in connection with the Third Party Software for decisions made or actions taken or not taken in rendering medical care or for information provided to Patient or insurance companies, government agencies, or other payers.
- Carrier Lines. Patient acknowledges that in connection with the access and use of OCM Services that such services will be provided over various facilities and communications lines, and information may be transmitted over local exchange and internet backbone carrier lines and through routers, switches, and other devices (collectively, "Carrier Lines") owned, maintained, and serviced by third-party carriers, utilities, and internet service providers, all of which are beyond OCM's control. OCM assumes no liability for or relating to the integrity, privacy, security, confidentiality, or use of any information while it is transmitted on the carrier lines, or any delay, failure, interruption, interception, loss, transmission, or corruption of any data or other information attributable to transmission on the carrier lines. Use of the Carrier Lines is solely at the Patient's risk and is subject to all applicable local, state, federal, and international laws.
- No Third-Party Beneficiary. No provision of this Agreement shall be construed to confer any third-party beneficiary rights to any non-party other than covered family members.
- Supervening Circumstances. OCM shall not be deemed in violation of any provision of this Agreement if it is prevented from performing any of its obligations by reason of: (a) severe weather and storms; (b) earthquakes or other natural occurrences; (c) strikes or other labor unrest; (d) power failures; (e) nuclear or other civil or military emergencies; (f) acts of legislative, judicial, executive, or administrative authorities; or (g) any other circumstances that are not within its reasonable control. This Section shall not apply to obligations imposed under applicable laws and regulations.
- Compliance. Any provision of law or regulation or judicial or administrative interpretation of same that invalidates, or otherwise is inconsistent with the terms of this Agreement that, in the reasonable judgment of either party, would cause one or both parties to be in violation of law or regulation shall be deemed to have suspended the terms of this Agreement; provided, however, that the parties shall exercise their best efforts to accommodate the terms and intent of this Agreement to the greatest extent possible consistent with the requirements of law and regulations.
- Severability. If any part, term or provision of this Agreement is held by a court of competent jurisdiction to be illegal or unenforceable, the remaining portions or provisions of this Agreement shall not be affected, and the rights and obligations of the Parties shall be construed and enforced as if this Agreement did not contain the particular part, term or provision held to be invalid, unless to do so would contravene the present valid and legal intent of the Parties.
- Survival. All provisions of this Agreement that by their nature or express terms survive the expiration or termination of this Agreement, shall survive such expiration or termination.

- Governing Law; Venue. This Agreement shall be enforced and construed in accordance with the laws of the State of New Jersey. Jurisdiction of any litigation with respect to this Agreement shall be in New Jersey, with venue in a court of competent jurisdiction or any other court having competent jurisdiction in the State of New Jersey. The only information released shall be the minimum necessary. In any action, declaratory or otherwise, arising out of this Agreement, the prevailing party shall be awarded reasonable attorney's fees and related costs to be paid by the other party.
- Entire Agreement. This Agreement, including any exhibits or schedules annexed hereto, constitutes the entire understanding and agreement between the parties with regard to all matters herein. There are no other agreements, conditions or representations, oral or written, express or implied, with regard thereto. This Agreement supersedes, in the entirety, any and all previous agreements, whether oral or written, between the parties concerning the subject matter hereof.
- Counterparts. This Agreement may be signed in any number of counterparts, no one of which need by signed by more than one party, and all such counterparts, when duly executed, will be considered an original of one and the same document.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

X_____ (Name)

X_____ (Signature)

_____ (Date)

Patient Consent for Telehealth Services

I hereby request, consent and authorize OnCall Medical, LLC, and its affiliates and agents (collectively, the "Company") and their employed or contracted physicians, physician assistants, nurse practitioners or other licensed health care professionals (the "Professionals"), to utilize Telehealth** through the Company's proprietary systems, methods and protocols to access, diagnose, consult, treat and educate myself and those I am authorized to represent (the "Services").

THE SERVICES

1. I understand that the Professionals will make every attempt to accurately access, diagnose and treat the health care condition for which I or those I am authorized to represent present to the Company or the Professionals.

2. I understand that the Services are self-pay, even if deemed to be a covered service under any health insurance plan or program that I or those I am authorized to represent are enrolled under at the time the Service is provided. I agree not to bill any private commercial insurer or federal or state health care program (i.e. Medicare, Medicaid, Tri-Care, Veterans Affairs, Federal Employee Health Benefits, etc.) even if deemed to be a covered service under such third-party insurance plan, and acknowledge that neither the Company nor the Professionals will bill any third-party health insurance plan for the Services provided.

3. I understand that the service fees due to the Company DO NOT include the costs of any treatment, procedure, service, medicine, drug or product provided by separate independent individuals or entities that may be prescribed*** or recommended by the Company or the Professional. I understand that I and those I am authorized to represent may receive one or more separate bills for such prescription medicines and other treatments, procedures, services or products and I am wholly responsible for payment of such costs, and further understand, that the independent entities and individuals will have their own billing and collection practices.

4. I understand that once the Professional decides on any prescription medicines or other treatment, procedure, service or product, if any, it is my responsibility to read and understand the risks and the potential side-effect profile and the adverse drug interactions of the medications and any other medications I may be taking concurrently, or consult with my primary care or specialty physician and pharmacist regarding the same, and ultimately to determine if I accept the risks.

5. I understand that it is my right to contact my primary care or specialty physician before starting any prescription medicines or other treatment, procedure, service or product or change my behavior based on any prescription, diagnosis, recommendation or education by the Company or the Professional in the course of the Service provided, to confirm that my primary care or specialty physician approves of the regimen.

6. I understand that all health care treatments can have potential adverse side effects and I accept responsibility for such potential adverse outcomes. If adverse effects are noted, I understand that it is my responsibility to stop any prescription medicines or other treatment, procedure, service or product prescribed or recommended by the Company or the Professional, and to report any adverse side-effects to the Company, the Professional, my primary care or specialty physician, or go to the nearest Emergency Room if I have any reason to suspect that I have a medical emergency.

7. I acknowledge that the Professionals shall exercise reasonable medical judgment in delivery of the Services provided, if any, but the condition for which I or those I am authorized to represent may seek a diagnosis, consultation or treatment may worsen after the Service provided, and both I and those I am authorized to represent are subject to the risks described above, including risks that the condition may worsen. I agree that I will not be entitled to a refund or recompense from Company or the Professionals for any reason, including poor outcomes.

8. I WILL INFORM THE COMPANY OR THE PROFESSIONAL OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO RECEIVE THE SERVICES PROVIDED OR THAT WOULD BE RELEVANT TO THE SERVICES THEMSELVES. IN PARTICULAR, I UNDERSTAND THAT IF I AM PLANNING TO BECOME PREGNANT, AM CURRENTLY PREGNANT, BECOME PREGNANT, OR AM BREASTFEEDING, THAT I WILL: (A) ADVISE COMPANY AND THE PROFESSIONALS OF THIS FACT; AND (B) ASK MY OB/GYN OR PEDIATRICIAN IF THE TREATMENTS RECOMMENDED BY THE PROFESSIONALS ARE ACCEPTABLE DURING THIS PERIOD OF TIME.

9. I understand that it is my sole responsibility to communicate and provide the Company and the Professionals with detailed, accurate and complete information concerning medical, medication and other history, allergies to medications and procedures, physical, mental and other relevant symptoms and conditions, and any other information or records requested or pertinent to the diagnosis and treatment of myself or those I am authorized to represent. I understand that, as with any service, to the extent that information is not provided or, if provided, is not detailed, accurate and complete, the services provided by the Company and the Professionals may be materially affected. I assume all risks, and assume full responsibility and waive all claims against the Company and the Professionals for personal injury, death or damages of any kind and agrees to the extent permitted by applicable law to defend, indemnify and hold harmless the Company and the Professionals from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from the failure to provide pertinent information and/or the failure to provide accurate and/or complete information as required.

LIMITED NATURE OF RELATIONSHIP

1. TO THE EXTENT ALLOWABLE BY LAW, THE SERVICES PROVIDED, IF ANY, ARE NOT INTENDED TO CREATE, NOR DO THEY CREATE, ANY PRACTITIONER-PATIENT RELATIONSHIP WITH THE COMPANY OR THE PROFESSIONALS, EXCEPT WITH THE PROFESSIONALS, FOR THE LIMITED PURPOSES OF PROVIDING THE SERVICES.

2. I UNDERSTAND THAT THE PRACTITIONER -PATIENT RELATIONSHIP, IF CREATED, IS EXPLICITLY LIMITED IN NATURE TO THE SERVICES, PROVIDED AND NOTHING ELSE. I UNDERSTAND THAT I WILL NOT RECEIVE ANY SERVICES FROM THE COMPANY OR THE PROFESSIONALS OUTSIDE OF THE LIMITED SCOPE OF THE SERVICES. I AGREE THAT NEITHER THE COMPANY NOR THE PROFESSIONALS HAVE AN OBLIGATION TO ACCESS, DIAGNOSE, CONSULT, TREAT OR EDUCATE ME REGARDING ANY CONDITIONS BEYOND WHAT MAY BE DISCLOSED, DISCOVERED, EVALUATED OR DISCUSSED DURING THE SERVICES PROVIDED.

TELEHEALTH

1. I understand that I have the option to withhold or withdraw my consent to receive the Services via Telehealth at any time, but that doing so will cause the Company and the Professionals to discontinue providing subsequent Services, it being acknowledged that the Company and the Professionals will only be delivering Services via Telehealth. In such case, I understand that I will need to seek treatment and care elsewhere.

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2. I acknowledge and accept that the physical examination portion of the Service, if any, will be delivered via Telehealth in reliance upon either video, images, telephone consultation, questionnaire, medical records or otherwise. I accept this, with full knowledge of all potential benefits and consequences, and deem this method of physical examination appropriate and complete.

3. I understand that due to a specific medical condition or technical problems, a face-to-face consultation may be necessary after the Services provided, if any, and/or the Professional may not be able to accurately diagnose the condition due to limitations inherent in using Telehealth.

4. I understand that federal and state laws concerning the confidentiality of person health information apply to services delivered and information acquired via Telehealth, including patient access and amendments to medical records. I understand that in rare circumstances, security safeguards and protocols could fail causing a breach of patient privacy.

I have read and understand the written information provided above. I agree that the information provided above adequately explains the Services, along with the risks and benefits of said Services. I have had the opportunity to ask questions about this information – if I had any questions, all of my questions have been answered in full by the Company. By electronically signing this form, I acknowledge and agree to all of the above, and certify that I have no questions and/or have had my questions answered in full.

Further, I represent that I have read and fully understood and agreed to: (i) the Company Private Pay Agreement; (ii) the Company Notice of Medical Information Privacy Practices; (iii) the Company Website Privacy Policy; and(iv) the Company Website Terms of Use. [CM1]

By signing this Informed Consent, I am agreeing to conduct transactions electronically, and intend for my electronic signature to be a binding electronic signature/contractual obligation on myself and those I am authorized to represent. Further, I understand and acknowledge that I am digitally receiving a copy of this Agreement concurrently upon execution to print and/or retain a copy of this Agreement.

**"Telehealth" means the use of electronic information and communication technologies as a mode of delivering health care services and public health to facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

***Online prescriptions will only be issued when indicated and approved by a physician, and as permitted by law in your state.

X_____ (Name)

X_____ (Signature)

_____ (Date)