CONSENT TO TREAT AND FINANCIAL AGREEMENT

Consent to Treat. You, for yourself, or as a personal representative of the patient, voluntarily consent to all medical treatment and health care-related services that the caregivers at our Clinic consider to be necessary for the patient. You understand that caregivers include physicians, technicians, nurses, and other qualified personnel, which may also include appropriately supervised students and residents, who shall perform services and procedures as may be necessary in accordance with the judgment of the attending medical provider(s). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If you want any HIV testing to be performed anonymously, you will tell the caregiver. You understand that the patient's medical information may be shared with other providers who are involved in the patient's care and treatment, and you consent to such disclosure. The patient's lab samples may be used to perform routine quality assurance testing. You are aware that the practice of medicine and surgery is not an exact science; no guarantees have been made about the results of treatments or examinations.

Medical Photography. You acknowledge that a copy of the patient's photograph ID may be taken for Chart identification and documentation purposes for the patient's electronic health record and is the property of Clinic unless consent is withdrawn in writing. If treatment requires medical photography (e.g., photographs, videos), you consent to such medical photography and consent to the use of these photographs and any other records for medical care and medical documentation purposes.

You understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. You also understand it is your responsibility to assure those accompanying the patient comply with this requirement.

Financial Agreement

Financial Responsibility. You agree to the following:

(a) Subject to applicable law and the terms and conditions of any applicable contract between Clinic and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient, you will be financially responsible and obligated to pay Clinic for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.

(b) Except as required by law, you assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer. You are responsible for providing accurate insurance information at the time of service. If this is not done, the patient will be responsible for paying the full amount, except for services subject to payment under applicable state worker's compensation laws or where another guarantor is responsible by law. You are also financially responsible for any balance, including co-pays, deductibles, and non-covered services. You also agree to complete all necessary paperwork for claims to be paid by the patient's insurance company and accept full liability for all charges if payment is not made on behalf of the patient's insurance company.

(c) Subject to applicable law, and in consideration of all health care services rendered or about to be rendered, you agree to be financially responsible and obligated to pay Clinic for the patient balances due.

(d) Consent to Contact. You authorize the Clinic and all clinical providers who have provided care to the patient, along with any billing services, collection agencies or other agents who may work on their

behalf, to make contact on the cell and/or other phone number provided using automated telephone dialing systems, text messaging systems, electronic mail , or other computer assisted technology to provide messages (including pre-recorded or text messages) about the patient's account, payment due dates, missed payments, information for or related to medical goods and/or services provided, and other health care information. You promise to notify the Clinic in writing within 30 days if the patient phone number(s) change and understand that the Clinic will continue to use the number provided unless a notice of change is provided. You give permission for the Clinic to communicate information to you via electronic mail and understand that such information may not be encrypted or secure. To the extent allowed by law, the Clinic will not be liable to you for any calls or electronic communications, even if information is communicated to an unintended recipient.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered, you hereby assign to Clinic all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Clinic's regular and customary charges for the health care services rendered. You authorize such payments from applicable insurance carriers, third party payers, and other third- parties. A list of usual and customary charges is available upon request. You consent to any request for review or appeal by Clinic to challenge a determination of benefits made by a third-party payer.

Missed Appointment Notification. To provide optimal care to all our patients, we ask that you give us a 24-hour notice if you need to cancel a scheduled appointment. Multiple missed appointments negatively impact our practice and the healthcare we provide to our patients. Therefore, at the discretion of the Clinic, if the patient has more than three "no shows" within a twelve-month period, the patient may be subject to dismissal from our practice.

Acknowledgements

Receipt of Notice of Privacy Practices. You have received or have been offered a copy of the Notice of Privacy Practices which describes how the patient's health information may be used or disclosed by the Clinic. It is understood that this Notice is provided the first time the patient receives services and then only when a significant change is made. Otherwise, it is available by request or on the clinic's website.

Open Payments Database. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. This database can be found at https://openpaymentsdata.cms.gov

Receipt of Copy of this Consent and Financial Agreement. You have received a copy of this fully signed and dated form and a copy will be retained in the patient's medical record maintained by the Clinic.

By signing below, the patient or their personal representative has read and understands this form and accepts its terms and conditions, and that it is being signed by the patient or the patient's authorized representative.

_____ _____

Patient/Personal Representative Signature Date

_____

Printed Name of Patient or Personal Representative

If signed by the Personal Representative Provide Relationship to Patient: _____