THE WELLNESS LOUNGE (TWL) CONSENT FORMS

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to TWL, its affiliates and its employees. TWL will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by TWL. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA").
A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

2 Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information. Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law;

• Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;

• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;

• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
• To your employer when we have provided health care to you at the request of your employer;

• To a government oversight agency conducting audits, investigations, civil or criminal proceedings;

• Court or administrative ordered subpoena or discovery request;

• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;

• To coroners and/or funeral directors consistent with law;

• If necessary to arrange an organ or tissue donation from you or a transplant for you;

• If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and

• To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION: Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public. Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for: • Public health activities; • Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes; • Treatment and payment purposes; • Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence; • Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities; 4 • Providing you with a copy of your health information or an accounting of disclosures; • Disclosures required by law; • Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise

expressly permitted by other law; or • Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:
Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a «Patient Access to Health Information Form» from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration.
All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an «Amendment Request Form» from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. «Accounting Request Forms» are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid TWL in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint. Office for Civil Rights Department of HHS Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278 Voice Phone (212) 264-3313 FAX (212) 264-3039 TDD (212) 264-2355
For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the TWL Privacy Officer by phone at (972)-701-0199_or at the following address: 12200 Park central drive suite 110 Dallas Texas 75251.
This Notice of Privacy Practices is also available on our [Practice Name] web page at www.thewellnesslounge.us

TELEMEDICINE/ELECTRONIC CONSENT

Telemedicine care consults and assisted telemedicine care consults involve the use of electronic communications and other technology to enable health care providers at a different location than the patient to evaluate, diagnose, treat, provide opinion, follow-up and/or educate the patient. On-location care consults (in- person care, house call) involves medical care via an in-person evaluation directly at the site of where the patient is located, outside of a physician's medical office or hospital. These health care providers may be physicians, nurse practitioners, physician assistants, dietitians, physical therapists, among other licensed professionals ("Healthcare Provider(s)").

Electronically transmitted information may be used in all services provided. The technology and information that may be utilized include any/all of the following: medical records, medical images, live two-way audio and video, email, cellular phones, output data from medical devices or apps, sound or video files, and other forms of telecommunication.

The electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient health information and will include adequate administrative, physical, and technical measures to safeguard the data and to protect the data from potential risks and intentional or unintentional corruption.

Risks of Telemedicine: There may be potential risks associated with the use of telemedicine. Risks include, but are not limited to: Information transmitted may not be sufficient (poor audio or video quality, distorted or interrupted medical information due to technical difficulties, poor resolution of data or images, or lost connection) to allow for appropriate medical decision making by the Health Care Provider;

Delays or insufficient information to make a medical decision due to deficiencies or failures of equipment; Security protocols could fail, causing a breach of privacy of personal health information; There may be incidental access to the patient's information by unauthorized persons; A lack of access to complete medical records may result in adverse drug interactions or reactions or other medical judgment errors; A Healthcare Provider may not be able to provide medical treatment via telemedicine or provide or arrange emergency care that is required; and

Not every medical condition can be evaluated using telemedicine. The Healthcare Provider will inform you if this occurs and a house call may be required to further diagnose. This may incur additional fees.

Risks of On-Location Care Consults (House-calls):

There may be potential risks associated with the use of on-location care consults. Risks include, but are not limited to: The environment in which the patient is located and requesting to be seen in may not be ideal for an adequate exam, which can hinder medical decision making and the ability to provide care;

Due to the mobile nature of providing this type of service, medical equipment may be unavailable or inadequate for the situation in which a client is requesting to be seen and a Health Care Provider may not be able to provide the medical treatment needed; While all necessary precautions are taken prior to performing any procedures, the conditions under which the procedures are performed may not be ideal which can adversely affect the outcome of the procedure; and

A lack of access to complete medical records may result in adverse drug interactions or reactions or other medical judgment errors.

By Checking the Box (Signing, Acknowledging) for this document, I understand and agree to the following:

I wish to engage The Wellness Lounge, LLC, for a consultation with a Healthcare Provider. Laws that protect privacy and confidentiality of medical information for in-person care also apply to telemedicine, and that no information obtained which identifies me will be disclosed without my consent, except as permitted by law. I have the right to withhold or withdraw consent to care during the course of that care at any time, without affecting my right to future care or treatment. I have the right, within the constraints of the law, to inspect information obtained and recorded in the course of a telemedicine or in-person interaction, and receive copies of this informational for a reasonable fee and in accordance with The Wellness Lounge, LLC standard policies and practices. I understand that telemedicine and in-person care may involve electronic communication of personal health information to other medical practitioners who may be located in other areas, including out of state. I understand that there are certain benefits to using telemedicine or in-person care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse. Health Care Providers are limited in their clinical liability towards me for telemedicine consults or onlocation care consults as circumstances may not be optimal or complete. I agree to not hold The Wellness Lounge, LLC or any of its Healthcare Providers liable for opinions, diagnostic or therapeutic, provided based on these consultations. There may be a delay in arranging an appointment either for telemedicine consults or on-location care consults, and access to care is not guaranteed. I have the right to seek alternative forms of healthcare at any point in time, including during a telemedicine or on-location care consultation. These alternative forms may include going to a clinic, doctor's office, urgent care, emergency room, or any other care provider that I feel may be able to address my medical situation. Additionally, I may elect to call my own personal healthcare provider to seek guidance. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, at a testing facility, or at the direction of a Healthcare Provider.

I understand that others non-medical personnel may be present during my encounter. They are also required to maintain confidentiality of my information. I will be informed of their presence and be given the right to request: (i) omission of specific details of medical history/physical exam that are deemed sensitive to me; and (ii) termination of the consultation at any time.

I understand that other The Wellness Lounge, LLC professional personnel may be present on a live video feed during my encounter. They are also required to maintain confidentiality of my information. I will be informed of their presence and be given the right to request: (i) omission of specific details of medical history/physical exam that are deemed sensitive to me; and (ii) termination of the consultation at any time.

I understand that a bill may occur both from the telemedicine service provider AND a facility fee may be charged from the site at which I was located at the time of a consult (for example nursing home, hospital, dialysis center, etc.)

I have read and understood the information provided regarding telemedicine, and all of my questions have been answered. If I do not understand, I have the right to seek answers to my questions to my level of satisfaction prior to engaging in the interaction.

I am authorizing The Wellness Lounge, LLC, and its Healthcare Providers to provide me with their observations, treatments, and recommendations regarding my medical condition.

I understand that my condition may require a referral to a specialist for further evaluation and treatment.

OVER THE PHONE CONSENT
Intake and information taken over the phone

Patient information is protected under The privacy rule (HIPPA ACT) any information given over the phone to The Wellness Lounge, LLC or a staff member is protected under such rule. The information provided is used for the purpose of patient's treatment.

I consented verbally to allow The Wellness Lounge, LLC and staff to obtain my patient history over the phone. Including and not limited to demographics, medical history, details regarding my upcoming visit. A copy of the completed paperwork was provided to me to review and sign at my appointment.

On The Wellness Lounge, LLC and its Healthcare Providers may refuse telemedicine service or on-location care consults in the event such visits are impracticable or not helpful to me in The Wellness Lounge, LLC sole The Wellness Lounge, LLC and its Healthcare Providers do not assume primary responsibility for me as a patient and may not have the ability to see me at all times (such as nights or weekends) or respond to my immediate medical needs. IN THE EVENT OF AN EMERGENCY, SEEK MEDICAL TREATMENT FROM A PRIMARY PHYSICIAN OR HOSPITAL IMMEDIATELY.

By Checking the Box (Signing, Acknowledging) this "INFORMED CONSENT TO TREAT", I hereby state that I have read, understood, and agree to the terms of this document.

CONSENT FOR TREATMENT

The undersigned consents to performance of medical services at The Wellness Lounge. This may include medical evaluation, procedures and treatment. Such procedures may include, but are not limited to: IV placement, X-rays, wound repair, blood draw and incision and drainage of abscesses. Treatment modalities include oral, intravenous, intramuscular, subcutaneous and inhaled medications, fracture treatment including splints and slings, wound repair including bio- occlusive glue and sutures. I understand that medical care is not an exact science and that no guarantee or warrantee is being made as to my examination, treatment, result or outcome. We are not an Emergency Room and are unable to provide medical services for life-threatening and/or serious illnesses. If you believe you have a lifethreatening and/or serious illness, please call 911 or go directly to an Emergency Room. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. However, I understand that doing so may hinder my treatment and/or medical outcome. All practitioners (physicians, physician assistants) furnishing services to the undersigned are The Wellness Lounge, are owners or independent contractors.

NOTIFICATION TO CONSUMERS Physician assistants are licensed and regulated by the Physician Assistant Board, nurse practitioners are licensed and regulated by the Texas Board of Registered Nurses, physicians are licensed and regulated by the Texas Medical Board. CONSENT TO USE AND DISCLOSE INFORMATION I agree and consent to the use and disclose of my health information for the purpose of treatment, payment from third party payers, and other healthcare operations, such as the maintenance

of medical records, communication of health information with other health professional who contribute to my care, and quality peer reviews and assessments.

PRIVACY NOTICE ACKNOWLEDGEMENT I have received a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act.

ACCIDENTAL BODILY FLUID EXPOSURE TO HEALTHCARE WORKER In the case of my bodily fluid exposure to a healthcare employee, I consent to testing, which may include, but not limited to, HIV or Hepatitis, to determine the presence of any communicable disease for the benefit of the exposed employee. I understand that these test results do not become a part of my medical record.

CONSENT TO PHOTOGRAPH I grant permission for The Wellness Lounge, to take photographs, should the need arise, for purpose of my treatment during my health evaluation and treatment.

CONSENT TO TEXT I grant permission for The Wellness Lounge, to send me text messages regarding wait times, my appointments, follow up questions, billing questions and attempts to collect payment the need arise.

PERSONAL VALUABLES Although the facility will make all reasonable efforts in safeguarding my valuables, I understand that The Wellness Lounge, is not responsible for the loss or damage of personal valuables.

ASSIGNMENT OF INSURANCE BENEFITS I assign The Wellness Lounge, all rights, title, and interest in any and all health insurance, including Medicare and/or health plan proceeds/benefits from any plan(s) arising from the provision of any goods and services provided The Wellness Lounge, and/or physicians/ healthcare providers thereof. At The Wellness Lounge, election, I also assign all of my rights and interest in all such insurance benefits or proceeds, including but not limited to the right to appeal any denial of benefits or to file any lawfully authorized lien necessary to secure payment from any third party or a third party's Insurer. I understand that I am financially responsible for the services rendered by The Wellness Lounge, and agree to immediately remit all payments received from insurance for those services. I agree to cooperate with Direct Urgent Care or its agent in collecting any such benefits. This assignment shall not obligate The Wellness Lounge, to file any appeal or perfect any such lien and nothing herein shall relieve me from direct financial responsibility for any charges not paid by an Insurer.

FINANCIAL RESPONSIBILITY Agreed upon payment are due at time of service including copays or Prompt Pay fees. We accept credit cards. No cash or checks. I acknowledge that many insurers will only pay for services that they determine to be medically necessary and that meet other coverage requirements. For example, some insurers require prior authorization for certain services. If my insurer determines that the services, or any part of them, are not medically necessary or fail to meet other coverage requirements, the insurer may deny payment for that service. If the insurer denies payment for the visit, I (patient or guarantor) agree to pay the current cash rate for house calls. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law. The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's agent to execute this Consent to Evaluation and Treatment and to accept its terms.

NOTICE TO DAY CARE PROVIDERS/SCHOOLS I, the parent, give consent to The Wellness Lounge to render medical services and/or treatment to my child at the facility where my child attends school/daycare without my physical presence. I understand and agree that a licensed childcare worker from my child's school will be present during the examination. I can opt to join via a telemedicine feature if available. The Wellness Lounge agrees to provide information regarding assessment and diagnosis and treatment plan with me.