Terms & Conditions for Service with

Express Health Systems (Form TCS-EHS-20v1)

Express Health Systems (**EHS**), and its affiliate companies, throughout this form hereafter may be referred to collectively as “EHS”. Multiple websites are owned/managed by EHS and each of these state that they are part of EHS on those various websites/domains. By agreeing to the “Terms & Conditions for Service” (hereafter may be referred to collectively as “Terms of Service” or “Terms”) with EHS I attest that I am voluntarily accepting and agreeing to all found within this heading/document, including all forms to follow. I acknowledge that it is my responsibility to review carefully and comprehend fully all discussed within this section prior to agreeing to these Terms of Service with EHS.

My acceptance of these Terms of Service indicates that I understand and agree to all found within this section. I declare under penalty of perjury that the preceding and foregoing is true and correct. My acceptance of these Terms of Service constitutes my legally valid and binding signature. For avoidance of any doubt, the terms "EHS", "we", "us", or "our" refers to Express Health Systems and/or its affiliates and the terms “I”, "you", “my” and "yours" refer to the person having service/s provided to them by EHS.

I am aware that I can view Terms of Service via an online platform. I accept EHS’ online Terms of Service form as fulfillment of EHS’ responsibility to provide me a copy of these Terms. I understand that EHS will provide me a physical copy of these Terms of Services/waivers/forms upon my request. I acknowledge that I have either received a physical copy of these waivers/forms or that I have declined to receive physical copies of them. I understand that some aspects of these Terms of Service/Waivers/Forms may not apply to me, such as direct face-to-face patients in a physical clinic only vs Telemedicine only patients, etc. With that in mind I am agreeing to any and all aspects of these Terms of Service/Waivers/Forms that apply/could apply to me.

Form TCS-EHS-20v1 includes this heading plus each of the following forms listed in this document below: Form ABN-EHS-20v1, Form LSW-EHS-20v1, Form DA-EHS-20v1, Form WH-EHS-20v1, Form MIW-EHS20-v1, Form PRA-EHS-20v1, and Form HIPPA-EHS-20v1.

ADVANCE BENEFICIARY NOTICE (ABN) (Form ABN-EHS-20v1)

My medical insurance providers, regardless of whether they are a private sector based medical insurance company (such as Blue Cross Blue Shield, Aetna, United Healthcare, Cigna, Humana, etc.), hereafter may collectively referred to as “your” or “my” “Private Medical Insurance Coverage” or “Private Insurance”. Additionally, any government based/related medical insurance company (such as Medicare, Medicaid, CHIPS, TriCare, Worker’s Compensation Insurance/Worker’s Comp, etc.), hereafter may collectively be referred to as “your” or “my” “Government Medical Insurance Coverage” or “Government Insurance”. I understand that by choosing to receive care from EHS that they will only bill Private Insurance, and that they will NOT bill Government Insurance. If my Private Insurance fails to

cover care provided by EHS and/or if a deductible applies per my Private Insurance Policy/Policies that I will be personally held responsible financially for care provided by EHS. By choosing to receive services from EHS I am voluntarily agreeing to waive any and all rights that are afforded me by any and all entities that are part of my government medical insurance coverage as they relate to my care provided by EHS. I understand that EHS will not bill Medicare, or any other government insurance entity/entities that constitute my government medical insurance coverage, for any service provided to me by EHS. I understand that I am required to pay for EHS services directly in the event that my private insurance fails to cover EHS expenses. I understand that my government medical insurance coverage will not reimburse me for my expenses with EHS. Medicare, and other entities within my government medical insurance coverage, often do not cover all health care expenses either in part or completely. Medicare, and other entities that constitute my government medical insurance coverage, only pay for covered items and services when Medicare, or others, rules are met. The fact that Medicare, and other entities that constitute my government medical insurance coverage, will not pay for a service/s or product/s does not mean that you should not receive it. There may be a good reason your doctor/medical clinician recommended it or that you have voluntarily elected to use such services. Right now, in your case, Medicare, and other entities that constitute my government medical insurance coverage, may or may not pay for the services and/or procedures indicated below:

SERVICES / PROCEDURES

Some and/or all services provided at or with any of EHS' affiliate companies.

REASON

Some entities, such as EHS, who do not wish to enroll in the Medicare, and other entities that constitute my government medical insurance coverage, program may "opt-out" of Medicare, and other entities that constitute my government medical insurance coverage. This means that neither the entity (in this case EHS), nor the beneficiary (in this case you the patient) submits the bill to any of your government controlled/related medical insurance coverage for services rendered. Instead, the beneficiary (you) pays the entity (EHS) out of your pocket if and only if your private insurance fails to cover all expenses related to care provided to you by EHS. Additionally, neither party (you or EHS) is to seek or be reimbursed by Medicare, or any other government controlled/related entity that constitutes my medical insurance coverage. By agreeing to the Terms of Service with EHS I am entering a binding private contract that prevents EHS and me from receiving payment from Medicare or any other government controlled/related entity that constitutes my medical insurance coverage for any services performed by EHS. EHS has opted-out of Medicare and all other entities that constitute your government medical insurance coverage.

Whether any non-government medical insurance coverage providers will allow your expenses with EHS to be covered by their plan with you and/or permit them to be applied towards your deductible with them is their choice alone. I understand and acknowledge that EHS has no control over this, and that EHS makes no guarantees whether any of my nongovernment medical insurance coverage providers will or will not allow my expenses with EHS to be applied towards my deductible or for reimbursement with them. I furthermore acknowledge that I agree to allow EHS to share information necessary with any and all of my private insurance companies in order to seek compensation direct to EHS for care EHS provided me. I am aware that EHS can provide me their billing information they provided any and all of my private insurance companies.

The purpose of this ABN form, and the remaining forms found within EHS' Terms of Services, is to help you make an informed choice about whether or not you wish to receive EHS' services &/or procedures, knowing that you will have to pay for them yourself in the event that your private medical insurance does not cover any or all of your bill with EHS. Additionally, this ABN form intends to make it clear to you that EHS will not bill any government insurance program for any care EHS provides you. If after reading the information contained here you still do not understand why Medicare, and/or any other entity within my government medical insurance coverage, will not be billed for services provided to me by EHS then simply ask one of our staff to help further explain it to you. You will have to pay for services provided to you by us yourself directly if and only if your private medical insurance fails to cover your bill with EHS in full. If you have any questions regarding expenses, services, or EHS policies ask our staff until you are satisfied. It is your responsibility to understand this prior to agreeing to have EHS provide you services. Agreeing to have services, procedures, and/or products provided to you by/with EHS is you verifying that you agree to the points made in these Terms of Services.

I acknowledge that any rights granted to me by any entity that constitutes my government medical insurance coverage are voluntarily made null-in-void/waived by me regarding any procedures, medical care, products, and/or any services provided by EHS at any of its physical EHS clinics, in-home visits, at facility visits (such as hospitals, in-patient hospice, in-patient rehab, and/or nursing homes/facilities, etc) its online platforms, and/or via any of its Telemedicine Systems. I understand and agree that any disputes that may arise regarding any of these issues, are null-in-void in favor of EHS in accordance with this document. By choosing to be a patient with EHS I waive my rights to have any care provided by them to be submitted by them, or me, to my government medical insurance coverage company/companies.

I fully accept the policies of EHS as described in these documents. I understand and accept that the rates set by EHS may or may not be different than the rates set by any of the entities that comprise my government medical insurance coverage. I understand and agree that any providers/clinicians of EHS that perform any procedures on me and/or provide me any other medical care, products, and/or services at EHS are not independently obligated and/or responsible for following any rights otherwise afforded me by any of the entities that make up my government medical insurance coverage. This statement is true regardless of whether or not any of EHS' medical care providers (clinician/s) that provided care for me at EHS are or are not listed as a provider for any of the entities that make up my government medical insurance coverage. This statement regarding the clinician is also true regardless of whether that clinician provides services for any practice/facility/entity outside of/separate from EHS and regardless of whether that other practice/facility/entity is or is not a provider for any entity within my government medical insurance coverage group. I understand and agree that any procedure/s, medical care, and/or service/s performed and/or provided by EHS is waived from the provider's duties and obligations set forth by my government medical insurance coverage regardless of the EHS clinic/patient location/service, duration, cost, or type of procedure/s/medical care/and/or service/s.

I understand I cannot appeal Medicare's, or any other government controlled/related medical insurance provider's, decision regarding any of this. I understand that EHS is not responsible to provide me information regarding what benefits I may or may not have from any or all of my government medical insurance coverage. I am aware that some state's Medicaid Programs may even provide transportation, such as MaineCare. I am also aware that many other great benefits may exist, including coverage for

Telemedicine visits for institutions that, unlike EHS, have opted-in/enrolled with various government medical insurance coverage entities.

LIMITED SCOPE OF CARE WAIVER ACKNOWLEDGMENT
(Form LSW-EHS-20v1)

I understand and agree to the following:

1. That EHS assists in managing only a limited aspect of my health care. That aspect being: coordinating care of home visits by nursing staff, wound care specialist, physical therapist, occupational therapist, and speech therapist; evaluation of patients after hospitalization and/or after surgery; minor urgent care type issues during home visits; house calls for non-emergent medical issues; providing temporary refills when necessary for patient's routine medications that are non-narcotics non-benzodiazepines; minor limited telemedicine urgent care type issues; home monitoring of patients.
2. That EHS does not intend to fill the role of a primary care physician/provider (PCP) or the roles of various sub-specialist physicians. Additionally, they are not a substitute for emergent care that needs to be provided by either an Emergency Department, a physical location based Urgent Care, a hospital, &/or a PCP or sub-specialist in their office. It is my responsibility alone to contact emergency services, such as 911, if I believe that I, or my dependents, are experiencing an emergent medical issue/condition.
3. That EHS advises that I see a PCP on a regular basis. Also, that I discuss all my medical care, prescriptions, supplements, and/or products provided by EHS to me with my PCP, my various other medical sub-specialist, and my pharmacist. I understand that EHS wishes to share my encounter with them to my PCP. I am also aware that they cannot release my EHS medical records to my PCP unless I give them consent as well as accurate contact information for my PCP. This is also true for any of my dependents that I am responsible for that I have receive care from EHS.
4. That if I experience any adverse reactions, side effects, or allergic reactions from any medications (prescription or non-prescription) that I receive from EHS, then it is my responsibility to stop taking the medication(s) immediately, seek medical advice, and to be evaluated by my PCP and/or emergency services providers as necessary. Additionally, I need to inform EHS of any such reactions.
5. That EHS, as well as other clinicians, cannot anticipate whether I will experience adverse reactions, side effects, or allergic reactions, after receiving any medication(s) EHS prescribes, or administers via injections, such says intramuscular, intravenous, and/or subcutaneous. I understand that such reactions can occur to anyone with any medication at any time and that EHS and the prescribing clinician is not at fault for such reactions.
6. EHS does not guarantee success at treating various medical conditions. I understand that various medical conditions are complex multifaceted issues with many variables. Various medical conditions include any/all conditions that may be treated in-person or via Telemedicine.
7. To increase my chances of success I must follow the recommendations of my EHS clinician/s, all of my other clinicians (PCP and subspecialists), and supportive staff with Home Rehab companies. Additionally, I need to take all medication(s) as prescribed, follow instructions from various home care/rehab specialist, follow all post-operative and all post-hospitalization

instructions, and dietary recommendations by my PCP and sub-specialist in order to improve my chance of success in treatment. Following all of these points decrease my risk of readmission to a hospital, repeat surgeries, poor outcomes, pain, permanent disability, and death, but they do not guarantee this.

8. EHS assumes that I have provided them with accurate information whether via an online form, written information, and/or via verbal communication. I understand that EHS will use the information I provide them to create my Medical Chart/Record. This will be stored as my Electronic Medical Record (EMR) with EHS and/or with companies it holds a Business Associates Agreement to compile/store information that composes my EMR. I understand that I can review this information. I understand that if I provide EHS with false or incomplete information the fault is mine alone and it can negatively impact my health/outcomes.
9. That it is my responsibility to inform EHS if I am pregnant, may be pregnant, and/or if I am breast feeding. If I fail to disclose that any of these are true for me then I understand that EHS will assume that I am not pregnant, I have no chance of being pregnant, and that I am not breast feeding. I understand that pregnancy and breast feeding a newborn guide and restrict the medical care and prescription medications that can be safely provided to a patient. I understand that certain medications and treatments can be harmful to a baby during pregnancy or while breast feeding. I acknowledge that it is my responsibility to know if I am or if I may be pregnant.
10. I am aware and acknowledge that if I am dissatisfied with any of my interactions with, care provided by, health outcomes, staff, or clinicians working with EHS or EHS in any way, that EHS' medical and non-medical administrative team are available for open discussions/dialogue to help resolve any issues. I am also aware that all patients, including those of EHS, have the right to contact State Medical Boards to file formal complaints about individual clinicians and/or medical institutions such as EHS and all of its affiliates. The National Practitioner Data Bank (NPDB) is a computer database ran by the US Department of Health and Human Services that lists damaging information about US physicians and other healthcare practitioners/clinicians. I understand that I can contact any State Medical Board on my own regarding any medical clinician, including those with EHS. I also understand that if I wish to contact EHS requesting contact information for any State Medical Board, that they will provide me with such information.
11. For treatment to occur between a medical practitioner/clinician and a patient a professional relationship must be created. This can be referred to as a provider-patient relationship. This can either be created via a face-to-face encounter in a patient's private place of residence/medical office/clinic/hospital/nursing home/in-patient hospice facility/etc. and/or through a Telemedicine Visit via a live interactive HIPAA compliant secure audio-video conference. Additionally, during times of significant public health concerns, such as a pandemic outbreak (example Covid19), State and/or Federal rules/regulations may or may not be eased to permit less restrictive means in order to create a patient-clinician relationship, such as a simple phone call. To truly create a provider-patient relationship EHS requires both acceptance of our Terms of Service plus either a face-to-face live interaction or a live interactive HIPAA complaint secure audio-video conference between the patient and one of our clinicians/clinicians contracted to provide medical treatment for our clients. During a significant public health concern, a phone call between a EHS clinician and a patient alone with acceptance of our Terms of Service may suffice to create a provider-patient relationship with EHS. A proper professional relationship

with a minor is established once the legally responsible individual for the minor patient has accepted our Terms of Service on behalf of the patient and the patient has spoken to one of our clinicians via either a face-to-face live interaction or a live interactive HIPAA complaint secure audio-video conference (exceptions under significant public concern may exist). A number of additional requirements must be meet, as well, in order to create a valid provider-patient relationship via Telemedicine. These requirements vary by State, but EHS' processes incorporate all State requirements within our system. By establishing a professional relationship with EHS I am agreeing/consenting to treatment by EHS.

12. Follow up care is often helpful, and sometimes it is necessary. This is true regarding in-office face-to-face visits as well as with Telemedicine patients. Scheduling a follow-up visit with EHS for Telemedicine is the same process as setting up an initial Telemedicine visit with us. Additionally, if a local face-to-face in-office visit with someone outside of the EHS system is necessary EHS' staff will provide you with local independent (meaning outside of EHS) clinicians and/or facilities upon request. Call our staff for more information regarding this and/or review your medical records with us contact our staff for further details.
13. Communications with Patients: There are multiple ways to interact with EHS. These include, but are not limited to, the following: at home visits, live interactive audio-video HIPAA Compliant Video Conferencing, Instant Messaging via our Patient Portal during regular business hours, static messaging via our Patient Portal while our clinics are closed, and phone calls. Our patients may be able to send us messages via our various websites. We receive these into our email system. We respond to these messages via email, but only with general information. We do not send any Protected Health Information (PHI) via email. Any PHI/sensitive information we send electronically is done so through our HIPAA Complaint Messaging System found within our Patient Portal. We aim to answer all messages by close of business during a business day or on the first open business day for messages sent after close of business. EHS does not directly communicate with our patients via our main public website/s. Our patients can message EHS in general through our Patient Portal.

DISCLAIMER ACKNOWLEDGEMENT (Form DA-EHS-20v1)

The information provided by EHS, on its printouts, on its websites, on its Patient Portal, and on its social media platforms, are not intended to provide or serve as an exhaustive or fully comprehensive medical resource regarding any number of various medical conditions. Likewise, descriptions found on our websites about medications (prescription and non-prescription) by EHS, if any exist, and injectable medications injected at any EHS facility, at a patient's private residence, at any facility the patient is in, or patient directed injections separate from an EHS facility, are not intended to provide an exhaustive or fully comprehensive medical resource regarding medications prescribed/ordered by EHS. Contraindications to the use of certain medications exist. Providing the most accurate medical information to EHS by our patients help minimize, although they can't guarantee, adverse reactions. If I provide EHS with false or incomplete information the fault is mine alone. As with all medications, those prescribed by EHS may produce side effects, allergic reactions, and other possible adverse reactions. For further information, EHS advises that you discuss all medical issues and medications with our clinicians as well as with your PCP, any other medical clinician/s providing you care, and your pharmacist. Additionally, many helpful tools can be found online. The Food and Drug Administration has a useful website, www.FDA.gov , with links to a wealth of information regarding medications and health related

topics. There are multiple privately-owned websites that also provide respected and highly detailed information regarding such subjects, free of charge. In addition to discussing all health and medication related issues with your PCP, EHS also encourages you to discuss these matters with your licensed health care provider with EHS. EHS is not claiming, nor intending to imply, that our treatments, and that of the rehab specialist we coordinate with, guarantees success simply by following the plan of care by EHS and the rehab specialist we coordinate with. All medical conditions involve complex issues that may or may not improve with treatment. Declining condition despite treatment with EHS, and/or any other medical care provider, is always a possibility. EHS is not responsible for the care/treatments provided by whatever Rehab Company we arrange to provide rehabilitative care, such as nursing, physical therapy, occupational therapy, and wound care. Any Rehab Company that we place orders with/coordinate with exist as an independent and distinct company from EHS. This is true even if the Rehab company's name is similar to ours. This is also true even if links exist between our websites and/or in the event that our information is imbedded within a Rehab Company's website/s. EHS is distinct from any Rehab company and complies with all State and Federal Laws regarding required separation of physician ran companies and rehab companies. EHS patients have the right to request a specific rehab company be contacted by EHS to carry out their rehab care. If a EHS patient does not specifically request a particular rehab company then the patient is agreeing to use the rehab company that EHS has contacted on my behalf.

WAIVER OF HEALTH / MEDICAL HISTORY / MEDICAL CONDITIONS (Form WH-EHS-20v1)

I understand that EHS is not intended to replace, nor fill the role of, a Primary Care Provider (PCP) or any/all other sub-specialist that make up my health care providers. I acknowledge that EHS has advised that I discuss with my PCP/sub-specialist any/all medication prescribed/ordered/coordinated for administration of and any/all therapy provided by/coordinated by EHS. I verify that EHS is not to be held responsible or liable if I choose to go against EHS's medical advice, and take any medication prescribed or provided to me by EHS in a manner not directed by EHS. I acknowledge that EHS has advised that I discuss any, and all, treatments/prescriptions/lifestyle recommendations from EHS with my PCP/sub-specialist. Also, I acknowledge that EHS advises that I follow the recommendations of my PCP, and those of my other subspecialist medical providers, over the recommendations of EHS. I verify that I do not/will not hold EHS liable/responsible for any rehab treatment coordinated by EHS nor any adverse reactions that I may have while taking any medication prescribed, provided to me by EHS, or coordinated administration of medications by a rehab company's staff. I understand and verify that this document is legally binding, and that to attempt to hold EHS, its clinicians, its Medical Malpractice &/or Business Insurance Provider responsible for any adverse reactions that may occur while I am taking any medication prescribed or provided to me by EHS, will result in legal action against me, to the fullest extent of the law, not only for damages to EHS' and its clinicians' reputations, but also for future loss in profits or clinician availability that may occur, and/or court/attorney(s)/legal fees that may occur due to said legal action. I understand that there is no expiration date or statute of limitation to this document's enforcement to Insurance Providers, the State of Texas and most other States in the USA, the Texas Medical Board and most other State Medical Boards within the USA, any Court of Law, and/or any other entity that EHS deems appropriate, should any undesirable event occur while I am taking, or after I have taken any medication prescribed or provided to me by EHS.

MEDICATION/INJECTION WAIVER ACKNOWLEDGMENT (Form MIW-EHS-20v1)

I understand that:

1. It is my responsibility to discuss all medication(s)/plan of care I receive from EHS with my EHS clinician, my PCP, my various sub-specialist physicians, and my pharmacist.
2. EHS, as well as other clinicians, cannot anticipate whether I will experience adverse reactions, side effects, or allergic reactions, to any medication(s) prescribed to or administered via injection from EHS or from a self-administered injection with a medicine prescribed by EHS. I understand that such reactions can occur to anyone, with any medication, at any time, and that the prescribing clinician and EHS is not a fault for such reactions.
3. If I experience any adverse reactions, side effects, or allergic reactions from a prescription orally taken medicine, an injection (whether intramuscular, subcutaneous, or intravenous) I receive at EHS's direction, or from a self-administered injection with a medicine prescribed by EHS, I understand that it is my responsibility to immediately seek to be evaluated by my EHS clinician, and/or my PCP, and/or by emergency services providers (911, an Emergency Department, etc.) .
4. I understand that any orally taken medicine or any injectable medication can produce minor, moderate, severe, or life-threatening adverse reactions, side effects, or allergic reactions (including anaphylactic reactions and death). I also understand that no adverse reactions may occur after taking an orally prescribed medicine or after receiving an injection of a medication.
5. I acknowledge and understand that EHS is not an emergency care center, and that they do not have equivalently trained staff, resources, or equipment comparable to an emergency care center. I acknowledge that patient care provided at a patient's residence, or other health care facilities, is not intended to handle/provide emergent care. If our patients/patient's responsible guardian feels the patient is experiencing a medical emergency, then they should call 911 to ensure they receive the proper care by the appropriate clinicians in the appropriate setting.
6. In the event of a serious adverse reaction from an orally taken medicine, a topical medicine, and/or an injection given at an EHS facility, in a private residence, or at another health care facility, I understand that the primary role EHS will perform will be their activation of the Emergency Medical Services (EMS) by calling 911. I understand that EHS would do all within their limited resources to render supportive care while awaiting the arrival of EMS staff members.
7. I acknowledge and understand that if I experience a severe reaction from an orally prescribed medication, a topically applied medicine, and/or an injection given at an EHS facility, in a private residence, or at another health care facility, and/or from a self-administered injection with a medicine prescribed by EHS, that EHS could not have predicted ahead of time me experiencing such a reaction, and that EHS is not at fault for such reactions.
8. I agree that I, nor any of my family/friends/or associates on my behalf, will hold EHS responsible should a negative experience or reaction occur after taking any orally prescribed medicine, a topically applied medicine, and/or receiving an injection at an EHS facility, and/or from a self-administered injection with a medicine prescribed by EHS. I will not seek legal action or judgement against EHS and affiliates in the event of said reaction. I understand that in the event of an adverse reaction, I will be held responsible for the expense of legal action in all forms, should I attempt to seek legal action against EHS and its affiliates.

Patient Responsibilities, Acknowledgments, and Agreements
(Form PRA-EHS-20v1)

In submitting my personal information and my health information (signs, symptoms, conditions, comments, answers to questions, fully-completed Health Information Form, and/or any online questionnaires) in connection with my request for services, the following statements are true:

1. I am an adult (at least 18 years of age) and/or I am an adult seeking care for my legal dependent.
2. I am voluntarily providing my health and medical information for the purposes of obtaining services through EHS.
3. I am competent to use the services offered by EHS, and I fully understand the material and information contained therein.
4. I voluntarily choose to seek a clinician consultation through telemedicine/online medicine, at a physical clinic location within EHS, at a private residence, or at another independent health care facility. I realize that for Telemedicine services that the consulting clinician will not conduct an in-person physical examination and will rely on the truthfulness and accuracy of the information I am providing to the EHS' staff and/or during a telephone and/or a teleconference video consultation.
5. I recognize that the consulting clinician reviewing my Health Information may, or may not, prescribe treatment based on my responses. Additionally, the exam performed by a EHS clinician will dictate what the clinician feels is appropriate for regarding my treatment (medications and/or other therapy, including rehab services). I understand that I may be responsible for the service fees/bill with EHS, in part or full, if my private insurance does not cover the care or only covers a portion of the care provided by EHS.
6. I am aware that my failure to provide truthful, accurate and complete information to the consulting clinician, and any other providers or staff with EHS, could result in an inappropriate treatment decision that could be harmful to me and/or ineffective. Therefore, I have responded, or will respond, to each question truthfully and accurately, and I acknowledge that I fully and completely disclosed any/all information concerning my current health and my past medical history.
7. I understand that EHS advises that I have a complete physical examination by a licensed medical clinician (PCP) at minimum yearly, and perhaps even more frequently as per recommendations by my PCP. I agree to inform my PCP about the treatments carried out by, or coordinated by, EHS. Additionally, I agree to inform my PCP about the products/medications/prescriptions ordered, administered, or supplied from/by EHS.
8. I will contact my PCP, my sub-specialist, and EHS, if I have questions, difficulties, or complications with recommended treatment/s. I will make my PCP aware of my visit and any medications administered and/or prescribed by EHS.
9. I will make any/all EHS clinicians that I see in the future aware of any changes to my medical condition since I was last seen by a EHS clinician regardless of the condition or setting that I am seen by a EHS clinician.
10. I understand that I will be given the opportunity to ask any and all questions about any tests, procedures, plan of care, rehab care being ordered, or medication(s) that may have been prescribed/administered/ordered for me or my dependents. It is my responsibility to seek

answers from EHS until I am satisfied and fully understand the plan of care, any associated risk(s), any possible complications, and fees/cost.

11. I understand that EHS' consulting clinicians are U.S. licensed practitioners, but that they are not my PCP and that they have no intention to fill the role of my PCP. I understand that the consulting clinician is compensated for reviewing my health information. The consulting clinician is compensated for this review, treatment plan, opinion, and consultation only.
12. I understand that there are risks, as well as benefits, in having tests and/or procedures performed, treatment or rehab performed, and/or when taking any medication. I agree that I will not hold EHS, the consulting clinician, &/or any entities, affiliates, employees, partners or agents associated with EHS responsible for any adverse effects/events caused by any medication(s) prescribed, procedures performed, tests ordered, or insufficient/inaccurate diagnosis and treatment procedures/plans of care ordered by the consulting clinician with EHS, that are due to the nature of the lack of an in person physical examination (i.e. Telemedicine limitations) and/or if I fail to provide reliable, truthful, and accurate information.
13. If paying by credit, debit card, FSA, HSA, or CareCredit Card, I acknowledge that I am the owner of said card/payment method, or I am permitted by law to use said card/payment method.
14. Regarding medical care provided via Telemedicine with EHS I understand, and agree, to the following (all within this section): I understand that a medical clinician who is currently licensed in the United States will review my Health Information. I understand that an EHS physician/advanced practice provider (Nurse Practitioner—NP or Physician Assistant—PA) licensed in my state will electronically send my prescription(s) to the local pharmacy of my choice in the state I live in. Another option for me is to have a pharmacy directly mail to me the medication(s) that were prescribed to me by an EHS clinician. I understand that if I choose this option that the pharmacy selected for this task will be financially independent from EHS (i.e. separate from EHS) and that it will be licensed to directly mail prescription medication(s) to patients. I understand that EHS does not prescribe any controlled substances to its Telemedicine patients from a Telemedicine visit. I understand that EHS is not a pharmacy and that EHS does not have any financial connection with any pharmacy.
15. I agree that if I, or any entity on my behalf, personally brings forth any dispute arising out of or related to the provision of services provided by the consulting clinician with EHS, or by their affiliates, employees, partners and agents, it will be subject to mandatory mediation. Should mediation fail to resolve the disputed issue(s), said dispute shall be subject to final and binding arbitration, and all parties will agree to be bound by the arbitration, which will be enforceable in a court, and parties waive any rights to bring suit before, during, or after agreeing to binding arbitration. These terms defined in this section are legally binding unless otherwise prohibited by applicable law. If no law prohibits this application in part, or full, then is will be applied to any legal disputes.
16. Any mediation, arbitration, administrative proceedings, or other proceedings shall be held in Tyler, Texas, unless all involved parties agree otherwise or if precedent law mandates another location. Such legal proceedings will be governed by the substantive law of the State of Texas without regard to conflicts of law. In the event that a legal matter arises (lawsuit against EHS) and a judgement is made in favor of EHS then the plaintiff against EHS will be required to cover all of EHS' related expenses including, but not limited to the following: lawyer/legal, mediation/arbitration/court fees, travel/lodging, lost wages/EHS expense for paying wages of all

of the staff involved in preparing for the case and/or being present at the trial, etc. This is true regardless of whether EHS counter sues or not.

17. I accept all risks, known and unknown, involved in, arising from, or related to taking the medication, products, procedures and treatment with/from EHS or the rehab carried out by a Rehab Company that EHS ordered services through. Subject to and without waiving any rights that may be conferred upon me under state or federal law, I will not seek indemnification and/or damages whatsoever of any kind from EHS, the consulting clinician, any entities, affiliates, employees, partners or agents associated with EHS for unintentional harmful acts, and I hereby hold harmless EHS from and against any and all liability relating to or arising out of my request for or receipt of medications/treatments in this manner.
18. I hereby release EHS, the consulting clinician, or any entities, affiliates, employees, partners or agents associated with EHS from any and all claims, that the clinician acted below the requisite standard of care on the basis that the clinician did not personally examine me (i.e. a limitation from having care provided via Telemedicine).
19. I hereby acknowledge that all information and service provided, are provided "as is" without warranty of any kind, expressed or implied.
20. If any provision of this agreement is held to be illegal, void, or unenforceable, then this agreement may be modified or amended only to the extent necessary to enable the remaining provisions to be in force and effect to the maximum degree in favor of EHS. If any individual, or multiple, clause(s) found within this document is(are) determined to be unlawful or unenforceable then that, or those, clause(s) alone will be deemed non-binding, but all other clauses/provisions will remain enforced/legally binding.
21. I understand the EHS reserves the right to search State Controlled Substance Programs to determine if I have been forthright with them.

HIPAA WAIVER OF AUTHORIZATION (Form HIPPA-EHS-20v1)

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This is to confirm that EHS is willing to collaborate with other medical practitioners, medical insurance entities, and government entities regarding a patient’s protected medical record and history if, and when, it is deemed necessary by any, or all, of the aforementioned entities to ensure the appropriate administration of your individual healthcare needs and/or continual adherence to federal and state mandated lawful practices. I understand records belong to EHS, but that the information in them is the patient’s information. EHS is required by law to keep information about you private, to give you this Notice about our privacy practices, and to follow the practices outlined in this Notice.

EHS is aware that the information shared involves the use and/or disclosure of Protected Health Information (PHI) for varying purposes as deemed necessary and appropriate by either our practitioner’s medical judgement and knowledge, another medical practitioner’s medical judgement and knowledge,

medical insurance requirements, and/or government entities without the explicit circumstantial authorization from the patient.

EHS is also aware that we must provide to our patients, upon request, an accounting of disclosures of their PHI under a waiver of authorization, unless otherwise mandated by law, as well as a copy of the HIPAA Notice of Privacy Practices. I am aware that I can view EHS' HIPPA form via an online platform. I accept EHS' online HIPPA form as fulfillment of EHS' responsibility to provide me a copy of HIPAA Notice of Privacy Practices. I, as a patient of EHS, understand that this information will be provided in printed form only if I specifically request a printed/physical copy of it. I acknowledge that I have either received a physical copy of these waivers/forms or that I have declined to receive physical copies of them.

Our practice will use and disclose your individually identifiable health information when required to do so by federal, state or local law concerning public health risks, health oversight risks, inspections, investigations, lawsuits and similar proceedings, and law enforcement requests, threats to health and safety to you or others, if you are a member of a military force or for National Security reasons.

Privacy of Electronic Prescriptions:

1. Privacy of electronically submitted prescriptions falls under HIPAA regulations based upon the recent e-prescribing final rule.
2. Authorization to access this data is role-based given the sensitivity associated with certain medications.
3. All treating health care providers have access to Controlled Substances, to reduce the incidences of drug-drug interactions, drug-condition contraindications, patient safety, etc.
4. I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, approve the submission of electronic prescription(s) and necessary accompanying healthcare information to healthcare providers, home health companies, rehabilitation companies, government entities, and/or my indicated pharmacy of choice. I agree to permit EHS to review any governmental based controlled substance database regarding any prescriptions I may have received from anyone anywhere at any time. I furthermore agree to permit EHS to directly contact my PCP, my medical subspecialist, and/or my pharmacies to gain information regarding me being prescribed any controlled substances.
5. I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, approve the submission of PHI and necessary accompanying information via phone conversation, email, and voicemail, provided appropriate identification measures are taken for patient verification.

If it is in our practitioner's better medical judgement to disclose your individually identifiable health information, this letter confirms a waiver of authorization for EHS to collaborate with and share your individually identifiable health information with other medical practitioners, home health companies, rehabilitation companies, government entities, and/or medical insurance entities, unless otherwise mandated by law, without your specific circumstantial consent, to ensure the patient's physical well-being and the administration of appropriate health care needs.

By accepting the Terms & Conditions for Service (Form TCSEHS18v1) with EHS, I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, authorize EHS to share my individually identifiable health information, or that of the EHS patient in the event these Terms & Conditions are being

authorized by a legal guardian/authorizing agent of a EHS patient, with health-care practitioners, home health companies, rehabilitation companies, government entities, and/or medical insurance facilities as needed or as seen appropriate in our clinician's better medical judgement, without explicit circumstantial approval from me, unless otherwise mandated by law.