OFFICE POLICIES AND MEDICAL CONSENT

Thank you for choosing Exer Urgent Care (Exer with Providence)! We are here for you 7 days a week from 9:00am to 9:00pm. At Exer there is no appointment necessary and we always have a board-certified emergency room doctor on staff. Exer is a Facey Medical Foundation Clinic staffed and managed by Exer. These policies and consents apply to the medical treatment you receive here.

CONSENT FOR TREATMENT: I hereby consent to allow Exer to provide medical treatment for myself/dependent minor. I understand that this care may include but is not limited to pathology, radiology and other diagnostic services as ordered by the physicians responsible for my care. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of the physicians.

ACKNOWLEDGEMENT: I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information and that failure to do so may adversely impact my care.

RELEASE OF INFORMATION: I authorize Exer to release information contained in my chart to relevant insurance companies, third parties, attorneys and employers as may be needed to process and manage my case and claims.

PRE-AUTHORIZATION: Some insurance companies require pre-authorization of services. If I am required to obtain an authorization for todays services and have not done so, I agree to assume all financial responsibility.

LABORATORY SERVICES: I acknowledge that certain lab tests may be sent to an independent lab for processing and hereby authorize results from these labs to be electronically delivered to Exers electronic medical record system and to Providences health information exchange. I understand that I will receive a separate bill for test results processed by an independent lab and agree to be financially responsible for the lab services provided to me.

MINORS RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed treatment and diagnostic for the minor.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the doctor prior to any X-Ray or onset of care.

WORKERS COMPENSATION NOTICE: Please note that Exer has service agreements with certain physicians who also provide services at the Huntington Hospital emergency department. For more information or to file a complaint, ask to speak to the clinic manager.

I have read and understand the office policies. I further understand that the office policies and consent apply to medical treatment I receive from Exer. I certify that any information I provide regarding my illness or condition is accurate and complete. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

FINANCIAL POLICIES

FINANCIAL POLICIES: If you have provided us with eligible insurance information, we will bill your insurance company for your visit. All co-payments and coinsurance, however, must be paid at the time of service. For patients with commercial insurance, we either require a credit card be kept on file for todays services or advance payment of your estimated patient responsibility at the time you receive the services. We are required by your insurance company to collect these amounts. After we submit the bill and your charges have been reconciled with your insurance company, your credit card will be charged for any remaining amount you owe and you will be sent a statement showing the amount charged. You may contact our billing department at (844) 232-0498 at any time before your card is charged to make alternative payment arrangements. You will be charged a $35 declined payment fee for any declined checks or credit card payments. Any charges that remain unpaid will be transferred to a collection agency. If you do not have insurance coverage you will be responsible for payment in full on the date the services are rendered, unless prior arrangements have been made. It is your responsibility to keep your personal, insurance and payment information (including change of address) updated with our office.

ASSIGNMENT OF BENEFITS: I hereby authorize all payments for covered and allowable medical services to be paid directly to Facey Medical Foundation d/b/a Exer with Providence. I hereby certify that to the best of my knowledge all statements contained herein are true. I understand that I am directly responsible for all charges incurred by myself and my dependents regardless of insurance coverage. In the case that a check is made to me or this office and me, for services rendered by this office, this document serves as a power of attorney for endorsement on my behalf.

PAYMENT: For your convenience we accept cash, checks, Visa, MasterCard, Discover Card, American Express.

CREDIT CARD AUTHORIZATION: I authorize Facey Medical Foundation d/b/a Exer with Providence to securely retain my credit card information on file and to charge my card for any

co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider, up to $500 per date of service. I understand that I may revoke this authorization in writing via certified mail sent to: Facey Medical Foundation, File 50670, Los Angeles, CA 90074. Any credits on my account may be returned to my credit card on file. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

COVID-19: Due to recent developments with COVID-19, the CARES Act and reimbursement policies of many insurance companies, we will not be collecting, in-office, the copays or coinsurance amounts due for visits associated with COVID-19 testing or treatment. Exer will bill you for any amounts due after your claim has been processed by your insurance company. Please contact your insurance company for further details.

WORK COMP: If you present for a workers compensation injury, and you are unable to provide all of the documentation required to submit a claim to your employers work comp insurance carrier, you agree to be financially responsible for the services you receive or to allow Exer to submit the charges directly to your employer for payment.

I have read and understand the office Financial Policies. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am responsible for the charges designated by my insurance company and am also responsible for charges not covered by insurance including finance fees. In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law.

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that a copy of the Notice of Privacy Practices has been provided to me to review outlining my Personal Health Information (PHI) and how that information is used.

ARBITRATION AGREEMENT

We believe arbitration is a faster and more efficient means of resolving disputes, differences of opinion and misunderstandings than a court proceeding. For this reason, prior to receiving services we request that patients agree to binding arbitration as provided herein. This Arbitration Agreement (the Agreement) is entered into by and between Exer Medical Corporation d/b/a Exer More Than Urgent Care and _____ (Patient), with respect to the following:

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. All parties to this Agreement, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Medical Malpractice Disputes and Claims Must Be Arbitrated; JAMS Arbitration. It is the intention of the parties that this Agreement shall cover all medical malpractice disputes, claims, and controversies whether such disputes arise out of Patients current course of treatment or out of any future course of treatment and shall bind all parties whose claims, whether in tort, contract or otherwise, may arise out of or relate to treatment or service, including diagnosis, assessment, instructions, treatment and care provided or not provided by Exer Medical Corporation, and all physicians, partners, associates, nurses, nurse practitioners, physician assistants, medical assistants and other employees, independent contractors, agents, clinics and/or representatives (hereinafter collectively referred to as Exer Medical). This Agreement shall bind Patient, any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence, giving rise to any claim. In the case of any pregnant mother, the term Patient herein shall mean both the mother and the mothers expected child or children. Any demand for arbitration must be submitted to Judicial Arbitration and Mediation Services, Inc. (JAMS) in accordance with applicable JAMS rules and procedures.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Exer Medical, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrators fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Exer Medical not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This Agreement may be revoked by the patient via written notice delivered to Exer Medical within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provisions(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT. Revised 09-01-2020

ELECTRONIC COMMUNICATIONS CONSENT

Exer Urgent Care would like to communicate with you via email, telephone voice mail, and text messages (the Services) to:
* Provide Reminders Regarding Upcoming Appointments
* Provide Test Results, Treatment Summaries and Recommendations for Follow-Up Care
* Distribute Financial/Billing Information Such as Invoices and Receipts

The purpose of this document is to obtain your consent and alert you to the risks, limitations and conditions of use for use of Services.

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks and limitations of the electronic communication Services more fully described below. I understand and accept the risks associated with the use of the electronic communication Services and I will follow the instructions outlined below, as well as any other conditions that Exer may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Provider or staff using the Services may not be encrypted. Despite this, I agree to communicate with the Provider/staff using these Services.

I acknowledge that either I or Exer may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Risk of using Electronic Communication

Exer will use reasonable means to protect the security and confidentiality of information sent and received using the Services, however, Exer cannot guarantee the security and confidentiality of electronic communications and wants to alert you of the following key risks:

* Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
* It is not possible to completely secure the information.
* Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
* Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.

* Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of Exer or you. Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
* Electronic communications maybe disclosed in accordance with a duty to report or a court order.

If email or text is used as an e-communication tool, the following are additional risks:

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* Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
* Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.
* Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, or for attending the Emergency Department when needed.
* You are responsible for following up on Exers electronic communication and for scheduling appointments where warranted.
* Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
* Exer may forward electronic communications to staff and those involved in the delivery and administration of your care. Exer might use one or more of the Services to communicate with those involved in your care.
* Exer will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
* Neither Exer or Facey are responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

You are responsible for informing Exer of any changes in your email address, mobile phone number, or other account information necessary to communicate via the Services.

If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call Exers office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

I acknowledge that I am signing this authorization through an electronic signature pad and that the electronic image will become the original document and that copies of this image may be used in place of the original.