OFFICE POLICIES AND MEDICAL CONSENT

Thank you for choosing Exer Urgent Care! Exer at Playa Vista 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 Medical Corporation (Exer Urgent Care) 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 physician or mid-level provider responsible for my care. I understand that I am under the care and supervision of the attending provider(s) and it is the responsibility of the staff to carry out the instructions of the provider.

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 today's 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 Exer's electronic medical record systems and to various health information exchanges. 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.

MINOR'S 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 provider prior to any X-Ray or onset of care.

WORKERS' COMPENSATION NOTICE: If you are being seen for a work-related injury or illness, you are entitled to treatment paid for by your employer or your employer's workers'

compensation insurance. If your injury is work related, Exer will send a report regarding your medical condition to your employer's workers' compensation insurer or to your employer if they are self-insured, as required by law. As a part of this process, a limited amount of your medical information will be shared with your employer.

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 employer's workers' compensation 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.

INDEPENDENT CONTRACTOR: 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.

OPEN PAYMENTS NOTICE: The Open Payments database is a Federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

FINANCIAL POLICY: 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 today's 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 (310) 525-3062 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.

I have read and understand the Office Policies and Medical Consent and understand that the Office Policies and Medical Consent apply to medical treatment I receive from Exer.

By signing below, I understand that I am agreeing to the Office Policies and Medical Consent. I further certify that any information I provide regarding my illness or condition, 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.

I understand that the foregoing provisions apply equally to myself or any individual for whom I am authorizing treatment.

I acknowledge that I am signing this document 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.

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Patient or Representative Signature