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.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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.

Patient Name: _____DOB: _____

Patient / Representative Signature: _____Date: _____

Notice of Privacy Practices and Acknowledgment

I have received or had the opportunity to review the Notice of Privacy Practices which is electronically available at https://exerurgentcare.com/privacy-practices-plv/ or by link during the registration process that describes how my medical information may be used and disclosed and how I can access this information. I also understand that I may access a copy of these forms at any time on the company's website.

Patient Name: _____DOB: _____

Patient / Representative Signature: _____Date: _____

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
- Request Your Feedback Such as Optional Patient Surveys

The purpose of this document is to obtain your consent and alert you to some of the risks, limitations, and conditions of use. Additionally, you understand that message and data rates may apply to SMS notifications.

Risk of using Electronic Communication

Exer will use reasonable means to protect the security and confidentiality of information sent and received, 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 stolen/hacked or 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 systems.
- 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 may be disclosed in accordance with a duty to report or a court order.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand the risks and limitations of the electronic communication Services. 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 encryption software may be used as a security mechanism for electronic communications. For a variety of reasons, it is possible that communications with the Provider or staff using the Services may not be encrypted. Despite this, I agree to unencrypted email or text communications with the Provider/staff.

I acknowledge that I am responsible for informing Exer of any changes in my email address, mobile phone number, or other account information.

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

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.

Patient Name: _____DOB: _____

Patient / Representative Signature: _____Date: _____

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 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 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 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 arbitrator's 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, 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, I acknowledge that I have received a copy and am agreeing to have any issue of medical malpractice decided by neutral arbitration.

NOTICE: BY SIGNING THIS FORM 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 01-01-2024

Patient Name: _____DOB: _____

Patient / Representative Signature: _____Date: _____