

FORM 1: DIRECT-PAY CLINICAL MEMBERSHIP AGREEMENT

1. Membership Cost Options

Differing membership options with cost.

- **Essential Care — Individual:** \$65 per month
- **Essential Care — Family:** \$115 per month
- **Complete Care — Individual:** \$150 per month
- **Complete Care — Family:** \$200 per month

For family memberships, you must list all covered individuals on the attached enrollment roster.

2. Membership Benefits

Essential Care includes:

- An acute care appointment offered within 24 hours of an acute care request, including nights, weekends, and holidays.
- Evaluation of common illnesses and minor medical concerns.
- Appropriate telehealth services when clinically suitable.
- Other services specifically identified in the written membership benefit schedule.

Complete Care includes all Essential Care benefits, plus:

- Expanded primary care and routine follow-up.
- Chronic condition monitoring and management.
- Medication management and care coordination.
- One therapy session per month for each covered family member.
- One monthly in-office ketamine treatment per membership, for clinically eligible patients.
- One Basic Hydration IV per membership per month, subject to clinical appropriateness.
- Integrated medical and behavioral health care planning.

All services are subject to clinical evaluation, medical appropriateness, provider availability, applicable protocols, and the written membership terms.

3. Minimum Commitment

I understand and agree that:

- My membership requires a minimum commitment of **three consecutive months**.
- I am responsible for the applicable monthly membership fees during the initial commitment period.
- My membership begins on the effective date specified below.
- After the initial three-month period, continuation and cancellation are governed by the written membership agreement.
- Any applicable cancellation notice, refund, early termination, or payment terms will be explained in the complete membership agreement.

4. Monthly Benefit Limitations

I understand that:

- Unused monthly benefits expire at the end of each membership month.
- Unused therapy sessions, ketamine treatments, and Basic Hydration IV benefits do not roll over.
- Complete Care includes one monthly ketamine treatment and one Basic Hydration IV per membership, not per covered family member.
- Each covered family member in Complete Care receives one therapy session per month.

- Additional services not included in my plan may result in additional charges.
- Clinical eligibility is not guaranteed merely by purchasing a membership.

5. Membership Is Not Insurance

I understand that the Direct-Pay Clinical Membership Program is not health insurance and does not replace health insurance. Emergency services, excluded services, outside referrals, and services not expressly included in my agreement may require separate payment.

6. Patient Acknowledgment

By signing below, I acknowledge that I have reviewed the membership benefits, pricing, minimum commitment, monthly expiration policy, and limitations. I have had the opportunity to ask questions and receive answers.

GENERAL CONSENT FOR MEDICAL CARE

I voluntarily consent to medical evaluation and treatment provided by appropriately licensed clinicians at Divine Health Group.

I understand that medical care may include obtaining a medical history, physical examination, assessment, diagnostic procedures, discussion of treatment options, and appropriate follow-up.

I understand and acknowledge that:

1. My clinician will explain the recommended care and material risks, benefits, and alternatives when appropriate.
2. No particular diagnosis, treatment outcome, or clinical result is guaranteed.
3. I may ask questions and may decline or withdraw consent for a proposed treatment, subject to applicable law and any immediate safety considerations.
4. My clinician may recommend additional testing, outside referrals, emergency evaluation, or a higher level of care.
5. My membership does not guarantee that every requested service is clinically appropriate or included in the monthly fee.
6. I am responsible for providing accurate information about my medical history, medications, allergies, supplements, and relevant health changes.

ACUTE CARE ACCESS AND EMERGENCY ACKNOWLEDGMENT

Divine Health Group offers patients an acute care appointment within 24 hours of an acute care request, including nights, weekends, and holidays, according to the membership program's stated terms.

I understand that:

- An appointment will be offered within the stated time frame; this does not guarantee a particular diagnosis, treatment, or outcome.
- The clinician will determine the appropriate appointment type and whether in-person, telehealth, emergency, or outside care is appropriate.
- Some symptoms require immediate emergency evaluation rather than a scheduled appointment.
- Membership access does not replace emergency medical services.

If I experience a medical emergency, I will call 911 or seek emergency care rather than waiting for a membership appointment.

Seek emergency medical care immediately for any of the following:

1. Chest pain or pressure — especially with shortness of breath, sweating, nausea, or pain radiating to the arm, jaw, or back.
2. Signs of a stroke — sudden facial drooping, arm weakness, difficulty speaking, confusion, or sudden vision loss.
3. Severe difficulty breathing — including severe asthma attacks or sudden shortness of breath.
4. Severe allergic reaction (anaphylaxis) — swelling of the tongue or throat, difficulty breathing, or fainting.
5. Uncontrolled bleeding — heavy bleeding that does not stop with direct pressure.
6. Loss of consciousness or new seizure — particularly a first seizure, prolonged seizure, or repeated seizures without recovery.
7. Severe abdominal pain — especially sudden onset, worsening pain, or pain accompanied by persistent vomiting.
8. Major trauma or serious injury — suspected broken bones with significant deformity, serious head injury, or injuries from major accidents.
9. Sudden severe headache — especially a sudden, explosive headache or one accompanied by neurological symptoms.
10. Suspected overdose or poisoning — including medication overdoses or exposure to toxic substances.
11. Severe infection or possible sepsis — confusion, extreme weakness, difficulty breathing, or signs of shock, especially with fever or suspected infection.
12. Pregnancy-related emergencies — heavy vaginal bleeding, severe abdominal pain, or fainting during pregnancy.
13. Acute mental health crisis — immediate risk of suicide, serious self-harm, or danger to others.
- 14.

Important: Call 911 for life-threatening symptoms rather than driving yourself. When in doubt, seek emergency evaluation.

TELEHEALTH CONSENT

I understand that telehealth involves receiving healthcare services through secure electronic communication, video, telephone, or other approved technology.

I understand and acknowledge that:

- Telehealth may be appropriate for some conditions but not others.
 - A remote assessment may limit the clinician's ability to perform a physical examination or obtain certain clinical information.
 - My clinician may recommend an in-person appointment, diagnostic testing, emergency services, or referral when necessary.
 - Electronic communication has potential privacy and security risks, even when reasonable safeguards are used.
 - I should provide my current physical location and a reliable callback number when requested for a telehealth encounter.
 - I may ask questions about telehealth or decline a telehealth encounter and discuss available alternatives.
 - Fees, coverage, and membership eligibility remain subject to my membership agreement.
-

INFORMED CONSENT FOR IN-OFFICE KETAMINE TREATMENT

Important: You will fill out a specific informed consent form related to Ketamine. Ketamine treatment is not guaranteed based on membership purchase.

I understand that my clinician may determine that ketamine is not appropriate for me, may delay treatment, or may discontinue treatment if safety concerns arise.

I agree to comply with the required monitoring and post-treatment instructions.

FORM 6: INFORMED CONSENT FOR BASIC HYDRATION IV

1. Proposed Service

I understand that Basic Hydration IV involves administration of an intravenous fluid solution for a clinically appropriate purpose. The actual formulation and treatment plan will be documented in my medical record.

2. Potential Benefits

Potential benefits may include replenishment of fluid in appropriate circumstances. The expected benefit depends on my condition and hydration status. IV hydration is not necessary or beneficial for everyone and is not a substitute for appropriate evaluation or treatment of an underlying medical condition.

3. Potential Risks

I understand that IV hydration may cause complications, including:

- Pain, bruising, bleeding, or discomfort at the insertion site.
- Irritation or inflammation of the vein.
- Infection.
- Infiltration or leakage of fluid into surrounding tissue.
- Allergic or other adverse reactions to administered ingredients.
- Fluid overload or worsening of certain heart or kidney conditions.
- Electrolyte or other complications depending on the solution and my health status.
- Rare but serious complications associated with intravenous access or treatment.
-

My clinician has explained the risks relevant to my proposed IV treatment.

4. Screening and Precautions

I agree to disclose relevant medical conditions, including heart disease, kidney disease, fluid restrictions, medication use, allergies, pregnancy when applicable, and any previous reaction to IV treatment.

I understand that the clinician may decline or modify treatment if it is not medically appropriate.

I agree to report pain, swelling, burning, shortness of breath, rash, dizziness, or other concerning symptoms during or after treatment.

5. Alternatives

Alternatives may include oral hydration, other clinically appropriate treatment, further evaluation, or no IV treatment.

6. Membership Benefit

I understand that Complete Care includes one Basic Hydration IV per membership per month, subject to clinical assessment and the membership agreement.

Unused monthly benefits expire at the end of the membership month. Additional treatments or services may incur additional charges.

Therapy

I understand that therapy is a collaborative process intended to support my identified treatment goals and emotional or behavioral health needs.

I understand and acknowledge that:

1. Therapy outcomes vary, and improvement is not guaranteed.
2. Therapy may involve discussing difficult experiences, emotions, relationships, or behavior patterns that can temporarily cause distress.
3. My therapist will explain the proposed approach, treatment goals, and reasonable alternatives.
4. Confidentiality is important but is subject to applicable legal exceptions, including certain safety concerns, mandatory reporting obligations, and valid legal requirements.
5. Information may be shared with other members of my care team when authorized or otherwise permitted by law.
6. I may ask questions about treatment and discuss concerns or alternatives with my therapist.
7. I understand the therapist's policies regarding appointments, cancellations, communication, emergencies, and after-hours availability.

Complete Care Therapy Benefit

I understand that Complete Care includes one therapy session per month for each covered family member. Unused sessions expire at the end of each membership month and do not roll over. Session duration, scheduling, provider availability, and any applicable limitations are governed by the membership agreement and therapy practice policies.

The membership therapy benefit does not mean that all behavioral health services, assessments, or additional sessions are included.

FINANCIAL RESPONSIBILITY AND PAYMENT AUTHORIZATION

I acknowledge and agree that:

- I am responsible for the membership fees associated with the plan I select.
- The minimum membership commitment is three consecutive months.
- I am responsible for the applicable monthly fees during the initial commitment period, subject to the written agreement and applicable law.
- Services not included in my plan may result in additional charges.
- Monthly benefits expire at the end of the applicable membership month.
- The practice will explain any known additional charges before providing services when reasonably practicable.
- Billing, payment methods, failed payments, refunds, cancellation, and early termination are governed by the written membership agreement.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered or provided access to Divine Health Group's Notice of Privacy Practices.

I understand that the notice explains how my protected health information may be used and disclosed, my rights regarding that information, and how I may contact the practice with privacy questions or complaints. This acknowledgment confirms receipt of the notice. It is not a substitute for any separate authorization required for a particular disclosure of health information.

FINAL PATIENT ACKNOWLEDGMENT

I acknowledge that I have received the applicable forms and had an opportunity to ask questions about Divine Health Group's membership program and proposed services.

I understand that separate treatment-specific consent may be required before particular procedures or treatments are performed.