INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

General Consent to Treatment:

You have the right, as a patient, to be informed about Your condition and recommended therapeutic or diagnostic procedures to be used so that You may make the decision whether or not to undergo any suggested treatment or procedure after being informed of the risks and benefits involved.

This consent provides our providers network and its healthcare providers (“Providers”) your permission to perform reasonable and necessary examinations, testing and treatment for You and continues until You revoke it in writing. You have the right at any time to discontinue Healthcare Services.

You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or even death. You understand that there are risks and benefits when receiving health care services. You understand that when You receive care, the risks and benefits of such care will be explained You and You will have the opportunity to ask Providers questions about such risks and benefits (and we encourage You to ask such questions). Unless otherwise discussed by your Provider, Services rendered by Providers are not intended to replace your primary care medical services.

You have disclosed all your known health conditions, allergies and medications You are taking, including herbal medications/supplements. You understand that certain treatment options that You may receive from or medications prescribed to You by your Provider can be dangerous and may result in medical care that is unnecessary if You have misrepresented your current health care condition and status. You have truthfully supplied information about your health care condition and status when answering any questions either on Platform or during any examination with a Provider.

Consent to remote treatment:

I hereby consent to remote diagnosis, treatment and education by Divine Health Group and it’s affiliates through the use of synchronous and asynchronous audio and video communication commonly known as telehealth or telemedicine technology (collectively, telehealth technology). I acknowledge that diagnosis, treatment and education through the use of telehealth technology will involve collecting information, including protected health information. I acknowledge my health information will be transmitted, stored and reviewed in compliance with applicable laws. I acknowledge that while telehealth technology may improve access to care and treatment outcomes, as with any technology facilitated diagnosis, treatment and/or education, there are risks and results cannot be guaranteed. The risks associated with telehealth technology include, and are not limited to, technical problems and equipment malfunctions that may results in omission, loss or compromise of information necessary for my diagnosis, treatment or education and that such omission, loss or compromise of information may result in my injury or death. I understand it is my responsibility to clearly explain symptoms, medical/surgical history and allergies, and to provide any other information as needed for your treatment plan.

No Show:

Customers are responsible to answer phone calls and/or text messages in order for us to provide care. If payment is made and the patient can not be reached. We will attempt to contact you 3 times within 24 hours. If you do not

make yourself available for treatment, you will receive a credit for a future visit. We will not automatically refund you. We make great effort to reach every patient.

LIMITATION ON LIABILITY AND DISCLAIMER OF WARRANTIES

By placing an order and/or participating in the Divine Health Group service, you agree Divine Health Group and its owner(s), parent, subsidiaries, affiliates, agents, representatives, and employees will have no liability whatsoever for any injuries, losses, claims, damages or any special, exemplary, punitive, Indirect, incidental or consequential damages of any kind.

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all questions or concerns to the treating clinician.

I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider. I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others.

· When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.

· When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.

· When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

I understand that if medications are prescribed, their duration of use, indication, and prescribed dosage may vary from the indication provided on the package insert or those set forth by the FDA also known as “off label”. Off-label prescribing is a common and legal practice in medicine. This practice is justified when scientific evidence suggests the efficacy and safety of a medication for an indication for which it does not have FDA approval and when the practice is supported by expert consensus or practice guidelines. Through shared decision making, patients and families are equal partners in clinical decision-making processes, which can help a physician carefully weigh risks and benefits of a given treatment according to the patient’s unique circumstances.

I understand that I have alternative treatment options available outside of Divine Health Group, including but not limited to Emergency Room services, Primary Care, and specialty care. I also understand that results are not guaranteed.

If there is a medical Emergency I will present to the nearest Emergency Room.

I accept the risks and complications of telehealth treatment and understand that no guarantees are implied as to the outcome of the treatment. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

I voluntarily request and consent to health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that are received.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices available to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Patient Signature or Guardian/Authorized Representative's Signature

Print Guardian/Authorized Representative's

Date of Signature