GENERAL CONSENT TO CARE

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Higher Ground Medical LLC on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of treatments, services, or examinations at Higher Ground Women's Health facilities.

I acknowledge that the medical history I provided to Higher Ground Women's Health is true and accurate and I am aware that any information I did not provide prior to treatment cannot hold any Higher Ground Women's Health personnel treating me responsible for loss or liability that may result due to my failure to provide such information.

I understand and agree that as a condition to my receiving treatment with Higher Ground Women's Health I will continue to visit my primary care physician, regardless of the extensive follow-ups specific to the diagnosis discussed by my Higher Ground Women's Health physician or treating personnel.

During my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures may be necessary. These procedures may be performed by physician(s), nurses, technicians, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my healthcare professional or physician to provide me with additional information. I understand Higher Ground Women's Health personnel and/or physicians may ask me to sign additional Informed Consent documents relating to specific procedures and treatments.

I agree not to give, sell, or allow anyone other than myself to use any medication provided to me through my treatment with Higher Ground Women's Health. I understand that Higher Ground Women's Health may have contracted with pharmacies for compounds and medications.

By signing this form I consent to Higher Ground Women's Health healthcare professionals performing medical treatment/services as they may deem reasonably necessary or desirable in

the exercise of their professional judgment, including those medical treatment/services that may be unforeseen or not known to be needed at the time this consent is obtained; and I acknowledges that I have been informed in general terms of the nature and purpose of the medical treatment/services: the material risks of the medical treatment/ services and practical alternatives to the medical treatment/services. I understand I can withdraw my consent at any time.

TELEMEDICINE

I understand that in certain situations the delivery of care may include telemedicine. Telemedicine is the use of information exchanged between clinician and patient via electronic communications to improve a patient's health status. Video conferencing technology will be used to affect a consultation. I understand this consultation will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider. I understand there are potential risks to this technology including interruptions and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

NOTICE OF PRIVACY

I acknowledge that I have reviewed the privacy policy on the Higher Ground Women's Health website. (www.highergroundwomenshealth.com)

FINANCIAL RESPONSIBILITY

I agree to accept financial responsibility for all services provided to me by Higher Ground Women's Health. I also agree to promptly pay all bills, in accordance with Higher Ground Women's Health applicable rates and terms. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the 9% per year.

FINANCIAL DISCLOSURE / REIMBURSEMENT FOR THOSE WITH INSURANCE

By signing below, you authorize Higher Ground Women's Health to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Higher Ground Women's Health, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Higher Ground Women's Health and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party

payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Higher Ground Women's Health does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

COPAYS/ DEDUCTIBLE

In addition to providing your insurance information you may be required to pay a co-pay or amount towards your deductible as deemed necessary.

TO THE PATIENT:

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Patient Name:

Patient Signature:

Date:

Witness Signature: