

PATIENT CONSENT AND AGREEMENT

Panagia Medical Recovery Clinic, PLLC (referred to herein as “Practice,” “we,” “us,” and/or “our”) maintains the policies below. By signing this Patient Consent and Agreement (“Agreement”), you agree to receive the services described below from Practice and its employees, contractors, and affiliated healthcare providers (“Staff”) and you authorize Practice to coordinate with your other healthcare providers on your behalf in accordance with the terms set forth below.

1. **Services.** You agree that the services that you receive from Practice will consist of addiction medicine and related services and products that we make available to our patients, that you request from time to time, and that we agree to provide to you at our discretion (collectively, “Services”). You agree to assume complete and full responsibility to take appropriate action with regard to the recommendations provided by us and our Staff. You represent to us that you are not relying on any statement made by us or our Staff that is not expressly stated in this Agreement. You agree to promptly inform Practice in the event that you do not follow (or stop following) any treatment plan or instructions provided by us and our Staff. You acknowledge that our physicians and healthcare providers are not your primary care providers. You agree that no one at the Practice is “on-call” or otherwise available for emergencies, after hours or on weekends, and that you are advised to obtain and maintain a primary care physician for your overall healthcare and on-call needs. You represent to us that you are not relying on any statement made by us or our Staff that is not expressly stated in this Agreement. You acknowledge and agree that visiting our website or electronic medical record portal, registration, scheduling an initial appointment, completion of forms (including, without limitation, this Agreement), and uploading records do not alone establish a physician-patient relationship or create any obligation on the part of Practice or our Staff to review submitted information before your initial consultation appointment with the Practice. We only have an established patient-physician relationship with you once you have attended a consultation or visit with a Practice physician.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

2. **Informed Consent for Services.** Practice may provide you with separate informed consent documents pertaining to specific Services offered. By signing this Agreement, those documents, and/or receiving any Services, you voluntarily consent, and authorize Practice, to perform Services and you agree that you have been informed about the Services and the purpose, procedures, contraindications, possible benefits and risks to your satisfaction and you accept them and consent to the Services prior to receiving such Services. You agree to inform Practice of any contraindications, considerations, adverse effects and changes that apply to you during the entirety of your receipt of Services. You understand that the provision of Services is not an exact science, and you acknowledge that no guarantees have been made to you concerning the results or outcome of the Services.

My signature below acknowledges that I have carefully read the information above and that I agree to it. I have informed Practice of any contraindications or considerations that apply to me.

3. **Informed Consent for Telemedicine Services.** You voluntarily consent, and authorize Practice, to perform Services via a telemedicine visit(s). You further agree to the following:
 - a. You agree that you are and will be located in Michigan at the time of each telemedicine visit and you agree that if you are not located in Michigan at the appointment time, you will be charged a cancellation fee pursuant to Section 5 below;
 - b. Practice has explained to you that the telemedicine visit(s) will not be the same as a direct patient/provider visit due to the fact that Practice’s provider(s) will not be in the same room as you;
 - c. You understand that your participation in the telemedicine visit is entirely voluntary. You also understand that either you or Practice’s provider can discontinue the telemedicine visit at any time for any reason;
 - d. The benefit of a telemedicine visit is that you will be able to be seen by the Practice in a convenient manner via a telemedicine platform. One alternative of telemedicine services would be to see a Practice provider (if available) or different providers in person;
 - e. You understand that although reasonable steps are taken to secure the telemedicine communications between you and Practice’s provider, there is no guarantee of security and there are potential risks involved in using the technology including, without limitation, interruptions, disconnections, unauthorized access, and technical difficulties;

- f. Practice has presented the above risks, benefits and alternatives to a telemedicine visit with you in a manner that you understand; and
- g. You have had the opportunity to ask questions regarding the use of Practice's telemedicine services for your telemedicine visit, and your questions have been answered to your satisfaction.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

4. **Service Fees.** You agree that you are financially responsible for and will pay all incurred charges for all Services provided by Practice without setoffs. You agree that payments are due in full at the time Services are rendered. **It is your responsibility to understand your insurance benefits including, without limitation, your copays, coverage and deductibles, and any required referrals. The Practice makes no representations regarding your insurance coverage or benefits and you agree that you are not relying on any statement or estimate made by Practice regarding your insurance benefits. You agree that prior authorizations, insurance verifications, and allowable amounts do not guaranty payment or eligibility for payment from your insurance company or third-party payor and you agree to be fully financially responsible for and pay for all incurred charges for all Services regardless of whether your insurance company or third-party payor pays for a portion of such Services or fails or refuses to pay for such Services.**

You agree that Practice will seek reimbursement from federal, state or third-party payors if Practice and its providers participate in such third-party payor's network and, in that event: (i) you hereby assign all payments and medical benefits directly to Practice for the Services it provides, (ii) you agree to cooperate with Practice by providing all necessary documents needed for third-party billing and you agree to send Practice any and all money that you receive directly from a federal, state or third-party payor for Services, and (iii) you agree that any deductibles or copays owed to Practice will not be waived. You agree that Practice and its providers may not participate in your insurance network or federal or state third-party payment program (e.g., commercial insurance, Medicaid, etc.). In the event that Practice and/or its providers do not participate in your insurance network or federal or state third-party payment program, you agree to make all payments in cash or other forms of accepted payment directly to Practice and you agree that the Practice shall bear no responsibility for the accuracy of any coding or claims-related requirements on any invoice or superbill that it may (but is not obligated to) provide to you. In the event that a third-party payor determines that Services are "not covered" or are otherwise denied, you agree to be responsible for all outstanding charges and you understand that you will be billed accordingly and will be responsible for immediate payment. You also understand that Practice will not become involved in disputes between you and your third-party payor regarding uncovered charges or reasons for denial. We take NO responsibility for any services denied or not covered by your third-party payor.

Practice maintains a standard fee schedule, subject to change from time to time. All Services shall be paid pursuant to Practice's then-current fee schedule in accordance with Practice's then-current payment policies which are included herein and may be set forth in other documentation provided by Practice at any time. Payments not received after 30 days of the due date or date of Services, whichever is earlier, will be assessed a late fee of \$50. This fee will accrue at a rate of \$50 per 30 days late. You understand that all returned checks will be subject to a \$25 returned check fee. You agree to provide the Practice's third party payment vendor, if any, with accurate and active credit card information and you agree that the Practice may charge your credit card in the amount of the payment owed for Services rendered on or after the date of Service(s). If your credit card declines for any reason or if you remove a payment method, you will be notified and required to provide accurate and active credit card information.

You understand that Practice has the right to forward unpaid accounts to a collections agency and you agree to bear and reimburse Practice for all costs including, without limitation, filing fees, service fees, and attorney fees associated with Practice's collection efforts on your account. Further, you agree that, to the extent allowed by applicable law, Practice has the right not to schedule you for further appointments and/or terminate its relationship with you if an unpaid and outstanding balance exists on your account. You also agree that all outstanding and past due balances must be paid at the time of scheduling any future Services. You understand that if fees are not paid in full, Services may be postponed or cancelled until payment is received.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

5. **Appointments.** In an effort to facilitate Practice's goal of maintaining an efficient schedule for all patients, we ask that you arrive and sign into the telehealth portal at least fifteen (15) minutes before your scheduled appointment time and that you complete any intake paperwork and questionnaires and email or upload any relevant documentation to Practice prior to your scheduled appointment date. You should contact Practice immediately if you expect to be delayed or if you are unable to keep your appointment in light of unforeseen circumstances. In general, we request that you provide at least 48 hours' advance notice of any cancellations for appointments. In the event of your late arrival for or missed or cancelled appointment with less than 48-hours' notice provided for appointments, you agree that your appointment may be rescheduled in Practice's discretion and that you may be required to pay a \$50 cancellation fee.

You agree that if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled by Practice, in its sole discretion; however you agree that if you arrive more than 20 minutes late for a scheduled appointment, Practice cannot guarantee to see you the same day and Practice reserves the right to cancel your appointment. If you fail to appear for an appointment (no show) without providing at least 48 hours' advance notice for 2 or more appointments within a one year period, Practice reserves the right to cancel all pending appointments and to discharge you as a patient and terminate this Agreement.

You agree to communicate with us and reply to our communications to you regarding Services, scheduling, payment, and any matter related thereto. Communications include patient portal communications, mail, email, text message, facsimile, phone call, and in-person communications. If you are nonresponsive to 3 or more of our communications over a 4 week period, Practice reserves the right to cancel all pending appointments and to discharge you as a patient and terminate this Agreement.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

6. **Email, Portal, and Text Communications.** All communications with Practice through Practice's patient portal are secure forms of communication. However, unencrypted emails and text messages are not recognized as secure communication forms and your decision to communicate via text or unencrypted emails on a non-confidential basis is at your risk. You agree not to send any information you consider private to Practice by unencrypted email or text. Practice is not responsible for the security of any information transmitted using any phone number or email address you provide. You agree that provider availability, computer concerns, internet problems, etc. may result in information not being read by the recipient in a timely fashion. You agree that you will not communicate time-sensitive information to Practice through email, our portal, or text. You agree that you will not consider appointments canceled through e-mail or text unless you get an email confirmation from Practice. **You agree not to use the portal, email, or text for any form of emergency communication.** If you consent to receive unencrypted texts or emails from Practice or any of their Staff, you acknowledge that you are aware of the above-mentioned risks of using text and/or email, you accept and agree to such risks and you agree to receive unencrypted text and/or email communications from Practice and their Staff.

My signature below acknowledges that I have carefully read the information above and that I agree to it and that I consent to receiving communications from Practice by unencrypted emails and/or text messages.

7. **Emergency Services.** You hereby agree that Practice will not be liable for any failure to provide, or delay in providing, Services to you in the event that Practice and its Staff are assisting another patient(s) in an emergency or in the event of other circumstances beyond the reasonable control of Practice. You agree that Practice may provide you with first aid or other emergency assistance at any time and location or contact others for the purposes of doing so. You agree to hold us harmless for any injury or damages caused by our participation or avoidance in an emergency. **In the event of an emergency, or a situation in which you could reasonably expect an emergency to arise, you agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.**

My signature below acknowledges that I have carefully read the information above and that I agree to it.

8. **Right of Cancellation or Termination.** You reserve the right to cancel your Services and this Agreement at any time for health reasons and/or personal reasons at your discretion or by the advice of any medical professionals upon written notice to Practice on a prospective basis. Practice also reserves the right not to provide the Services to you or to cancel any or all Services and this Agreement upon written notice to you at any time, including if we determine there is a risk to your or our health or safety. If you breach this Agreement, fail to communicate with us, harass, bully or otherwise cause harm or damage to us, our Staff and other personnel, customers, supplies, or equipment (collectively, a “Default”) we may cancel or suspend Services and terminate this Agreement.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

9. **Testimonials.** You are not required to provide any testimonials. However, to the extent that you provide a testimonial(s) via text, audio, and/or video (collectively, “Testimonials”) on Practice’s website or social media sites, you authorize the Testimonials to be used by Practice for purposes of professional publications, training, education, clinical evaluation, and marketing worldwide including, without limitation, on Practice’s website, email marketing campaigns, advertisements, brochures, social media accounts, platforms, and other promotional materials, and you understand that this may result in the publication and distribution of your information to the general public. You further agree to the following:
- a. You agree that your Testimonials reflect your real life experience with Practice and that you composed and submitted the Testimonials to Practice and Practice did not coach or suggest the wording of your Testimonials;
 - b. You agree that that you have not received and will not receive and that you waive any claim to receive any financial or other compensation, remuneration, or gain from Practice’s use of your Testimonials;
 - c. You agree that Practice may reprint, reproduce, and use your Testimonials at its discretion and you waive any claim to inspect, edit, or approve of Practice’s use of your Testimonials;
 - d. You waive any claim to copyright or libel as it relates to Practice’s use of your Testimonials;
 - e. You agree that Practice may use your Testimonials with or without any pseudo (pen) name credit;
 - f. You understand Practice does not condition treatment on your provision of Testimonials;
 - g. You understand that Practice makes no, and expressly disclaims, any warranty or representation of any kind, whether express, implied or arising by operation of law as it relates to Testimonials; and
 - h. If applicable, you may be asked to sign a HIPAA or similar authorization to the extent that we wish to use your protected health information (PHI) in connection with your Testimonial.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

10. **Patient Conduct.** Practice is committed to providing safe environments for all of its Staff free from any form of unlawful discrimination and harassment including, without limitation, sexual harassment. You understand and agree that Practice will not tolerate unlawful discrimination, harassment, bullying, or disrespectful behavior of any kind from you or others. You understand and agree that we strictly prohibit all weapons of any kind (guns, knives, etc.) at our locations. You understand and agree not to smoke or use vapes while at our locations. You agree not to take any recordings (video, voice, etc.) or photographs at our locations or of our Staff or other patients. You may not use, publish, or disseminate any of our confidential information or trade secrets without our express written consent. You will not directly or indirectly take any action or make any statement the effect of which is intended to or would reasonably be expected to directly or indirectly impair the goodwill, business or personal reputation, or in any material respect disparage, harass, disrespect, or defame Practice, Staff, or Services. You agree to provide accurate health information to Practice and that you will adhere to Practice policies and procedures. This Section shall survive expiration or termination of this Agreement.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

11. **Disclaimers and Limitation of Liability.** WE MAKE NO WARRANTY WHATSOEVER WITH RESPECT TO ANY SERVICES PROVIDED OR PRODUCTS SOLD INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY; WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE; WHETHER EXPRESS OR IMPLIED BY LAW, COURSE OF DEALING, COURSE OF PERFORMANCE, USAGE OF TRADE OR OTHERWISE. ALL WARRANTIES OF ANY KIND CONCERNING SERVICES AND

PRODUCTS SOLD ARE HEREBY DISCLAIMED. WE ARE NOT LIABLE TO YOU OR TO ANY OTHERS FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL OR PUNITIVE DAMAGES WHATSOEVER (INCLUDING, WITHOUT LIMITATION, DAMAGES FOR LOSS OF USE, WAGES, REVENUE OR PROFIT, BUSINESS INTERRUPTION, AND LOSS OF INFORMATION), WHETHER ARISING OUT OF BREACH OF CONTRACT, TORT (INCLUDING, WITHOUT LIMITATION, NEGLIGENCE), OR OTHERWISE, REGARDLESS OF WHETHER SUCH DAMAGE WAS FORESEEABLE AND WHETHER OR NOT YOU HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. TO THE EXTENT PERMISSIBLE BY LAW, OUR AGGREGATE LIABILITY TO YOU FOR ANY CLAIM SHALL NOT EXCEED THE TOTAL OF THE AMOUNTS PAID FOR THE IMPLICATED SERVICES AND/OR PRODUCTS. THIS SECTION SHALL SURVIVE TERMINATION OR EXPIRATION OF THIS AGREEMENT.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

12. **Release and Indemnification.** You acknowledge that Practice is not providing any products or services outside of Services and Practice is not liable for civil damages as a result of acts or omissions in performing Services. You hereby expressly, fully and forever agree, to the extent permissible by applicable law, to release, waive, indemnify, discharge, and hold harmless Practice, its owners, managers, members, investors, directors, officers, representatives, affiliates, employees, providers, agents, Staff, and contractors (collectively, the "Indemnified Parties") from, and covenant not to sue any Indemnified Parties for, any and all liabilities, claims, losses, judgments, damages, costs, demands, causes of action, injuries or illness (including death), compensatory damages, liquidated damages, punitive, compensatory or exemplary damages, all other damages, claims for costs and attorneys' fees, sums of money, wages, bonuses, benefits or any other liabilities of any nature whatsoever in law or equity, both past and present and whether known or unknown, suspected, claimed or unclaimed, liquidated or unliquidated ("Claims") regardless of any sole, concurrent or contributory negligence, acts, omissions or fault of Indemnified Parties, that you or any of your heirs, assigns, executors, personal and legal representatives, guardians, parents, durable powers of attorney, and next of kin may have at any time for any reason resulting from or related, indirectly or directly, in whole or in part, to: (a) services outside of the scope of Services; (b) damage, theft, or loss of your personal property, illness, harm, injury and/or death; (c) information provided to, or used or further disclosed by, our patient portal or electronic medical record system; and/or (d) breach of contract, tort (including, without limitation, negligence), or otherwise. You acknowledge that in releasing and agreeing to indemnify the Indemnified Parties pursuant to this Section, you are not relying upon any representations or warranties, oral or written, under oath or otherwise, from Practice or its Staff, other than those specifically stated in this Agreement, so that there can be no claim that would attack the validity of the terms of this Section. You expressly agree that this release is intended to be as broad and inclusive as permitted by the laws of the State of Michigan. This Section shall survive termination or expiration of this Agreement.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

13. **Dispute Resolution.** This Agreement is governed by Michigan law, irrespective of any choice of law statutes, principles, or rules. To the extent permissible by law, except for disputes concerning collection of sums due for Services rendered and claims for injunctive relief, all matters arising out of or related to this Agreement, including the arbitrability of disputes, will be resolved exclusively through binding arbitration before a panel of three arbitrators selected by us, who are not required to issue a reasoned award. Proceedings will be conducted by the American Arbitration Association (AAA) in Michigan in the city nearest to Practice under the United States Arbitration Act, and where not in conflict with the foregoing, the Michigan Arbitration Code and AAA Consumer Arbitration Rules. You agree to the exclusive jurisdiction of the state and federal courts presiding in Macomb County, Michigan and waive all defenses to the jurisdiction of those courts for all matters not subject to binding arbitration. The prevailing party may recover from the other party all expenses incurred in claims for breach of any of the provisions including attorney's fees and costs. In all other matters, each party will pay their own attorney's fees and costs.

WITHOUT LIMITING YOUR OBLIGATION TO ARBITRATE CLAIMS AS STATED ABOVE, YOU AGREE TO WAIVE ALL RIGHTS TO A JURY TRIAL AND COVENANT NOT TO SUE OR PARTICIPATE IN ANY

GROUP CLAIMS OR CLASS ACTIONS. HOWEVER, YOU ARE NOT WAIVING YOUR RIGHT TO DISPUTE RESOLUTION PURSUANT TO THIS SECTION.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

14. **Miscellaneous.** We are not liable for delays or events beyond our control. You acknowledge that this Agreement is a binding legal document that creates certain rights, responsibilities and obligations on the part of both parties. This Agreement shall be construed without regard to any presumptions or rules requiring construction against the drafting party. This is your entire agreement with us and supersedes all others concerning its subject matter. In the event of a conflict between the terms of this Agreement and any informed consent document or other document entered into between you and us, the terms of this Agreement will control and govern. All provisions, except those that obligate us to deliver goods and Services, will survive termination of this Agreement and are severable. No modifications or waivers are effective unless they are in writing and signed by us. We must consent in a signed writing to any transfers or assignments. Although this Agreement is binding on and inures to the benefit of permitted heirs, personal representatives, successors, and assigns, it does not confer any legal or equitable right, benefit, or remedy of any nature whatsoever on others.

My signature below acknowledges that I have carefully read the information above and that I agree to it.

Your signature below evidences your voluntary agreement to receive Services from Practice, and that you are the patient or are authorized to act on behalf of the patient to sign this Agreement. By signing below, you agree that you have read, understand, and agree to all of the statements contained in this Agreement. Your signature below further evidences that you have been informed about the Services and the purposes, procedures, possible benefits and risks to your satisfaction and you accept them and consent to the Services. You understand that the provision of Services is not an exact science, and you acknowledge that no guarantees have been made to you concerning the results or outcome of the Services. You agree that you have been given an opportunity to ask questions before you sign and your questions have been answered to your satisfaction, and you have been told that you can ask other questions at any time. You understand that your agreement is effective on the date signed below and that you may revoke your agreement in writing. Your revocation will not be effective for actions already taken by Practice or that are in progress and will only be prospectively effective.

Patient Signature: _____

Date: _____

Patient Printed Name: _____

(If applicable) Patient Parent/Guardian Signature: _____ Date: _____

Patient's Parent/Guardian Printed Name: _____