Mobile Care LLC
6825 East Tennessee Ave, Ste 325
Denver, Colorado, US - 80224

Boutique Medical Concierge Consent

Mobile Care LLC dba Boutique Medical

We look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care.

1. OFFICE POLICIES & FINANCIAL AGREEMENT

The policy of Mobile Care LLC to collect all payment information at the time services are initiated. For your convenience, we accept Venmo, visa, MasterCard and American Express. We do not accept any form of insurance presently. *

☐ **I understand**

Mobile Care LLC does not accept any form of insurance presently. You may choose to submit claims to your insurance company for reimbursement.

☐ **I understand**

You will be charged a Missed Appointment fee of $75.00 for any missed appointments or late cancellations (less than 2 hours notice). *

☐ **I understand**

2. INFORMED CONSENT AND REQUEST FOR MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.

Please read this agreement and sign and date the form at the bottom:

AUTHORIZATION FOR CONCIERGE SERVICES

Pursuant to this Client Registration Agreement, I authorize, Mobile Care LLC and any affiliates, employees or contractors to administer such medical, health care and/or nutrition services, treatments and procedures for me or my family members as deemed appropriate and necessary under the applicable circumstances. I understand that they will prescribe a program that may include conventional or western health care, nutritional therapies, functional medicine and other elements of integrative

medicine.

I understand that if any explanations as to benefits and/or risks and dangers of the prescribed treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. I understand that there are no warranties, representations or assurances of successful outcomes for me.

After reviewing the information herein and receiving answers to any questions related to this Agreement. As a patient seeking medical, health care and/or nutrition services, I understand that I am ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services).
I will report to Boutique Medical any matters arising out of treatments or services and schedule a consultation to conduct appropriate follow-up. I will promptly seek medical attention if I experience any unanticipated effects associated with treatments and services or if the treated condition worsens. If a medical emergency arises, I will call 911 or visit the nearest hospital emergency room. I understand that, Boutique Medical, does not provide emergency care.

APPOINTMENTS AND CANCELLATION POLICY

I understand that my appointment time with Mobile Care is reserved exclusively for my care for the duration of all scheduled visits. I understand that I am expected to keep all appointments as scheduled in order to ensure maximum progress in connection with

treatment and care and that if I am late for an appointment, the visit will end at the scheduled time and I will be responsible for the cost of the full visit. If I need to cancel or reschedule an appointment, I will call during business hours at least two hours in advance. No charge will apply in this situation. I understand that if I cancel an appointment during business hours less than 2 hours before the scheduled visit, or if I fail to show or cancel on the day of the appointment, I will be charged for the entire cost of the visit.

DURATION OF AGREEMENT, REVOCATIONS OF AUTHORIZATIONS AND AMENDMENTS

I may revoke the medical records release authorization in writing at any time and Mobile Care LLC and any affiliates or contractors will attempt to accommodate all reasonable requests. However, I understand that in some circumstances related to treatment, payment or health care operations, Mobile Care LLC and any affiliates or contractors may not be able to accommodate such requests. I further agree that, in no event, will any revocation of a prior authorization affect any of my other obligations in this Agreement. The rights and obligations of the parties herein shall be fully applicable and the respective rights and obligations of the parties shall survive expiration, cancellation or termination of this Agreement for any reason. I also certify that I am enrolled in this practice to receive medical and health care and for no other purpose. This Agreement and the Notice, along with any agreement to arbitrate, reflect the entire and exclusive agreement between us and supersedes any prior or other contemporaneous agreement. This Agreement may only be amended by a written document signed by Mobile Care LLC and any affiliates or contractors, and each of the undersigned

My signature below indicates I have received this notice and that I fully understand all its terms, including my responsibilities and assumed risks. I give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement and have received a copy of this notice.

Membership Agreement

Patient hereby agrees to enroll as a member in the Practice's Direct Primary Care Membership Program ("Membership Program") beginning on the Effective Date of payment. By being a member of the program, Patient shall be eligible to receive the

medical services described in the purchased or customized plan ("Covered Services"), attached at the time of purchase. Membership in the Practice's Membership Program includes only the Covered Services, as the Practice may choose in its sole discretion. The Practice shall provide at least sixty (60)-days' written notice of any change to the Covered Services listed in Exhibit A prior to such change going into effect.

All memberships are annual (12 month) memberships. Members can pay the annual in full upon execution of membership agreement. All memberships have a term of twelve (12) months from the effective date of this Membership Agreement. The Membership Agreement may thereafter be renewed in writing at the then-current membership rate. By mutual agreement of the parties to this agreement, one type of membership may be converted to another type of membership pursuant to a new contract with the Practice. The term of this membership may be extended as follows:

1. If the Practice temporarily closes for thirty (30) days or less, the term shall be extended for the number of days equal to the number of days that the Practice was closed (excluding holidays and any other days the facility is normally closed), at no additional cost to the member.

2. The Member may extend the term of this membership for 12 months within 30 days of this contract expiring.

The Member may also choose to upgrade services on the annual renewal date, or before the annual renewal date at a prorated amount, calculated by the number of months remaining in the existing plan multiplied by the monthly of the new plan

Member (or Member's legal representative) may cancel this Membership Agreement in accordance with the following:

1. Prior to receiving a fully executed copy of this contract, Member may cancel and receive a full refund, minus credit card processing fees.

2. If Member dies, the Members' legal representative must notify the Practice in writing of the Member's death.

3. If Member is deployed by the United States Military for a period of more than thirty (30) days, Member's fees from that date forward will be fully refunded.

4. If the Practice closes for more than thirty (30) days and fails to provide a comparable service within twenty-five (25) miles of the Practice, Member may cancel this contract upon written notice to Practice. Upon cancellation under this Paragraph, Member shall be entitled to a refund of all monies paid in excess of an amount computed by dividing the full contract price by the number of weeks in the contract term and multiplying the result by the number of weeks elapsed in the contract term.

The Practice may terminate this Membership Agreement upon providing Member advance written notice. Termination will be effective starting five business days after notification. Upon termination, the Practice shall comply with all rules and regulations of the State of Colorado Medical Board and State of Colorado Nurse Practice Act regarding the provision of emergent care for 30 days after termination and cooperate in the transfer of Patient's medical records to the Patients new primary care provider, upon

the Patient's written request and direction

All use of the Practice shall be undertaken at Member's sole risk, and the Practice and/or its Manager, agents, employees, contractors, or any other party operating under its direction or control shall not be liable for any harm, injuries or damage to Member or Member's property, or be subject to any claim, demand, liability or damages whatsoever, including, without limitation, those resulting from acts of active or passive negligence on the part of the Practice and/or its Manager, its successors or assigns, as well as its officers and agents, for all such claims, demands, liabilities, damages, actions or causes of actions.

Member will have access to the patient portal that will be available through an internet connection. Member acknowledges that the patient portal is maintained by a third party ("Charm dba MedicalMine")) in compliance with HIPAA. The Practice is not responsible for any breach of health information located in the patient portal.

Member acknowledge that communications with the provider and other providers using e-mail, facsimile, video chat, instant messaging, and cell phones outside of "Charm" are not guaranteed to be secure or confidential methods of communications. As such, Member expressly waives the providers' obligation to guarantee confidentiality with respect to correspondence using such means of communication. Member acknowledges that all such communications may become a part of Member's medical records. By providing Member's e-mail address to the Practice, Member authorizes the Practice, and its providers and staff to communicate with Member by email regarding Member's "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) Member acknowledges that: (a) E-mail is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access; (b) Although the providers will make all reasonable efforts to keep e-mail communications confidential and secure, neither the Practice, nor the providers can assure or guarantee the absolute confidentiality of e-mail communications; (c) In the discretion of the providers, e-mail communications may be made a part of the Member's permanent medical record; and (d) Member understands and agrees that email is not an appropriate means of communication regarding emergency or other time-sensitive issues, or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which the Member could reasonably expect to develop into an emergency, Member shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel. Neither the Practice, nor the provider will be liable to Member for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Member as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) failure of the practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of email communications by a third party; or (v) Member's failure to comply with the guidelines regarding the use of email communications set forth in this paragraph.

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Covered Services

1. General adult medical care for ages 18 and greater;

2. Same-day or next-day appointments at your home or office;

3. Comprehensive annual exam/executive physical, including preventative care;

4. Drawing, collecting and sending labs at the Practice, , Member's home or office, or any labcorp location found here: https://www.labcorp.com/labs-and-appointments;

5. Nutrition counseling;

6. Creation of an individualized goal-oriented health plan;

7. Coordination of care with specialists;

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Mobile Care LLC and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Name of Patient: *

Today's date: *

PATIENT SIGNATURE *