General Informed Consent and Request for Care

As a patient, I have the right to be informed of all material information associated with any procedure, so that I can make an informed decision regarding a proposed treatment. Material information includes all information the practitioner knows that would be regarded as significant by a reasonable person in my position. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Anatara Medicine and any of its affiliates. Anatara Medicine in these documents refers to Anatara and its practitioners, and any of our affiliates as "the Practice".

I, , hereby requested and consent to an initial evaluation with the Practice. Once

the initial examination is performed, the Practice may recommend a specific treatment or treatments, e.g., Intravenous therapies, Injection services, and other cutting-edge services as recommended by the Practice:

- A description of my present illness or the group of abnormalities, which might explain my complaints or symptoms, or optimizing benefits,
- The nature, purpose, goals and potential benefits of the proposed care,
- The practitioner's recommendations as to further diagnostic workup treatment, along with any alternative(s),
- The inherent risk, complications, potential risks or side effects of treatment or procedure,
- The probability or likelihood of success,
- Risks of doing nothing.

I understand that an evaluation and therapies at the Practice may include, but are not limited to:

- Physical exam typically includes, musculoskeletal, ears/eyes/nose/throat (EENT), heart and lung, orthopedic and neurological assessments,
- Common diagnostic procedures including venipuncture, imaging, laboratory testing, EKG
- Evaluation of blood, urine, stool, saliva, hair
- Gene therapy
- Soft tissue and osseous manipulation, PEMF, BEMER, Infrared Sauna
- Dietary advice and therapeutic nutrition based on traditional Korean and Chinese medicine theory (including use of foods, food diary, nutritional supplements and intramuscular vitamin injections),
- Trigger point injection therapy with vitamin substances, Prolozone injections
- RASHA and Emotional Freedom Technique (EFT)
- Aesthetic and hormone related services and procedures, including facial injections,
- Intravenous therapies, Chelation, Oxygen, Ozone Insufflation via rectal/vaginal, Botanical/herbal medicines,
- Homeopathic remedies (highly diluted quantities of naturally occurring substances),
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications
- Cancer Care Support to include Insulin Potentiation Therapy, Immunotherapy, and others
- Acupuncture Treatments
- Massage Therapy
- Lymphatic Massage Therapy

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissues or bone injury from physical manipulations; aggravation of pre-existing symptoms, potential risks or side effects from basic life support or resuscitation provided by our practitioners/staff, and even death.

Notice to pregnant women or women of child-bearing age: All female patients must alert the practitioner if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. It is the responsibility of the patient to notify the office if there is a chance of the pregnancy.

Notice to patients with bleeding disorders, pacemakers, known or new allergies, blood thinners, and/or cancer: For your safety, it is vital to alert your practitioner at the Practice of these conditions.

Please INITIAL the following:

☐ I understand that neither Dr. Herskowitz nor any other practitioner at the Practice are acting as my primary care physician. Although the practitioner may address issues affecting my general health, the Practice is focused on Integrative, Functional, and Complementary Medicine, and does not go through ANY medical insurance provider. I understand that it is in my best interest to follow up with a primary care physician to ensure that I am fully apprised of conventional means to address any medical conditions that I may have. The Practice is not hospital based. It is in within my best interest to inform the Practice of any other care I am receiving to assure my care is properly coordinated.

☐ I understand that practitioners at the Practice will only prescribe medications if he/she believes that they are in my best interest.

☐ I understand the U.S. Food and Drug Administration has not approved of most of the services provided at the Practice, as well as, cutting-edge therapies, nutritional, herbal, and homeopathic substances.

☐ I understand that cutting-edge refers to therapies that have not gone through rigorous double-blind placebo testing.

☐ I understand the possible side effects, complications, including hospitalization, even death, and other problems may be associated with some of the services I may request or the Practice may recommend.

☐ I understand that the Practice requires a physical exam routinely every 6 months in order to properly treat and manage my care, and acknowledge that the routine physical exam is a charged service.

☐ I understand that prior to receiving a recommended specific treatment, the Practice will discuss any material information with me, including the specific risks and benefits. Where the procedure is simple and/or the danger associated with the therapy is known to be remote, I understand that this form may be the only informed consent. For other proposed treatments, I will be informed of the material risks through a specific consent form and/or discussion with my practitioner.

☐ I understand that the practitioners typically order extensive laboratory testing. In order to have those results reviewed with me, the practitioners will schedule a consultation once all or partial results are in, and that I must pay for those consultations. If I decide to ask questions about those results outside of the consultation, I acknowledge that I will be billed for those questions, whether via email, portal, telemedicine/telephone or in- person.

☐ I may be offered to prepay for a package of services over a given amount of time. If I decide to stop the services prior to the end of the package, that I may request the difference and will be refunded via the same route that I paid the Practice.

☐ I understand and state that no promises, assurances, or guarantees of definite improvement or resolution have been made by the Practice. I understand that I can discontinue my chosen approaches at any time and my physician will not be prejudiced against me in any way. If I choose to consent to a proposed treatment, I believe the risks of my chosen service(s) to be worth taking in exchange for the therapy for my condition.

☐ I understand that any supplements or prescriptions that are shipped, mail order shipping costs are charged to my credit card on file automatically upon my request. Shipments are sent to arrive overnight unless otherwise directed, without requiring a signature. The Practice does not take responsibility for packages arriving late or not arriving at all. It is my responsibility to ensure the Practice has my correct shipping address on file..

I understand that the Practice will provide material information relevant to the proposed therapy, in addition to any consent forms, that would satisfy a reasonable person in my position. If after receiving this information, I still don't understand the risks involved for whatever reason (e.g. I have special needs), it is my responsibility to inform the Practice that I do not consent and to request any additional explanation of particular therapies and procedures.

By signing below, I acknowledge that I have read and understand this form. I also acknowledge that I have been provided ample time/opportunity to read this form or have it read to me. I understand all of the above and give written consent to receive an initial evaluation, and future services.

Credit Card Authorization Form and Cancellation Policy

Patient Name: Name on Card:

Credit Card Number Ending in: Expiration:

Billing Address:

I authorize the Practice to keep my credit card on file and bill my credit card for payment of services, laboratory testing, supplements, and shipments.

I certify that I am authorized to use this credit card. I also include any family members, ie., spouse, child, significant other, caretaker, etc., that wish to pay for my services, that their authorization for credit card charges on my behalf for my care at this center, and once services are rendered to me, that the credit card on file is automatically charged, and that their previously recorded signature is considered "on file" as our authorization.

Explanation of Payment and Cancellation Policy:
Payment is due at the time of service. We are an out-of-network office, meaning we do not accept any insurance for payment of our services.

At this Practice, we agree to service you, and therefore your bill is due at the time those services are rendered. We do not agree to handle your medical insurance, and therefore, offer no billing for our

services. You are responsible for payment in full. We offer no superbills because nearly all of the services we provide are considered nonconventional, and medical insurance does not cover the majority of the services we provide. If there are a few exceptions, insurance will only reimburse you/the patient, a small percentage of our services, this would include some consultations based on diagnosis code(s).

In receiving medical records, please note that we do not have the staffing to review, organize and upload extensive amounts of medical records, nor do we access 3rd party institutions. If in the event we are willing to receive such records in the office and not directly to our Electronic Medical Record (EMR) system, we will charge for those services: New patients with 50 or more pages, we charge a $200 minimum medical record admin fee, this is for the first hour. After that, we charge $20.00 per 15 minutes above and beyond the first hour for the preparation and organization of those records.

For the Practitioners to review those records, they charge a Record Review fee of $200 per practitioner.

Please be advised that we do not typically offer email consultations. However, if you email the office for any of the practitioners, and the email comprises questions concerning your plan, you will be charged for the time necessary for the practitioner to research, review and respond to your email. Your credit card on file will be charged for that day or the following business day. Your practitioner may decide that email communication is less efficient than an in-person or phone consultation. If your practitioner determines that your email is too complex and requires an in-depth explanation, you will be asked to schedule a phone or in-person consultation with your practitioner so that your question(s) may be adequately and appropriately addressed. The phone/video calls are billed at the regular, in-office rate with payment due via credit card at the end of each call.

I acknowledge:

If it is necessary to cancel or reschedule your scheduled appointment, we require that you call greater than (>) 48 hours, or 3 business days, in advance to the appointment time. Failure to notify our office >48 hours in advance may result in a charge equal to the fee of the scheduled consultation(s) and/or service(s).

I understand that the cancellation policy is >48 hours, 3 business days. If I do not provide greater than 48 hours of cancellation or rescheduling time, that the office has the right to charge my credit card on file for the services that I was scheduled for. There are special services that require a different cancelation fee. Please inquire if you have further questions.

We charge a $50.00 fee for any check that is returned, and will no longer accept that as payment for further services, unless that is a cashier's check.

If I am late to my appointment greater than 10 minutes, I may be charged for that entire time for a consultation or service that I was late for, and even though I was not present, I provide my consent to pay for that scheduled time.

I understand and agree to the terms of the Practice's payment and cancellations policies.

Patient's HIPPA Consent

To the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Anatara medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my care and services
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and therapies to my bill
- A means by which a third-party payer can verify that services billed were actually provided

- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information of Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that our clinic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out services, payment, or healthcare operations and that the organization is not required to carry out services, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Email Consent: This office follows HIPPA guidelines and is dedicated to keeping your online meeting platforms confidential. Despite our best efforts, due to the nature of i.e., email, text, phone calls, where third parties may have access to. We do not use an encrypted email portal, and therefore encourage you to use the secure messaging system through the Patient Portal to communicate with the office.

I understand that this office will not be responsible for information loss, delay or breaches in confidentiality including those due to technical factors, or what is reasonable beyond this office's control.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email, text, or any other type of communication method that we honor per your request.

Notice of Information of Practices

(Detailed Disclosure of Health Information)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

When you arrive at the Practice, a record of your care and services is initiated. Upon thorough examination and assessment, this record will typically contain your symptoms, examination and test results, diagnoses, services, and a plan for future care or services. This information, often referred to as your health or medical records, serves as a:

- Basis for planning your care
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care that you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating healthcare professionals
- A source of data for medical research
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

How We May Use or Disclose Your Health Information

1. Therapies. We will use your health information for your therapies. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded into your medical chart and used to determine the course of therapies that should work best for you. Your physician will document in your records his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to therapies. We will also provide your physician or a subsequent healthcare practitioner with copies of various reports that should assist him or her in treating you once you are discharged from our facility.
2. Reimbursement. We pledge our best efforts to provide you with the necessary forms and supportive information in a timely manner so as to optimize any potential reimbursement to you, though there is no guarantee for any or partial reimbursement. Any reimbursement from your insurance company should go directly to you. In this process, we will use your health information. For example, a bill may be sent to a third- party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As a reminder, since nearly all of our services are considered alternative or non-standard, the only items we provide superbills for, typically, are, with appropriate diagnosis codes, and (some) practitioner consultations; we do not provide superbills for other services. If you have questions about this, please contact the Patient Care Director prior to receiving any care.
3. Health care operations. We will use your health information for regular health operations. For example, members of the medical staff, the interdisciplinary team, or Consultants may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.
4. Business associates. There are some services provided in our organization through contacts with business associates. Examples include our accountants, consultants, and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.
5. Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or a personal representative, then we may leave a message for them at the phone number that they have provided us. e.g., on an answering machine or cell phone.
6. Communication with the family. Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

7. Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance in formation to enable product recalls, repairs or replacement.
8. Public health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We reserve the right to charge for forms as requested or records copied and supplied.
9. Law enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
10. Reports. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Your Health Information Rights

Although your health records are the physical property of the Practice, the information in your health record belongs to you. You have the following rights:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Practice's general health care operations, and/or to a particular family member, other relative or close friend. We ask that such requests be made in writing on a form provided by our facility.
  Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. For more information about this right, see 45 Code of Federal Regulations (C.F.R.) 164.524.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. We ask that you use the form provided by our facility to make such requests. For a request form, please contact our Patient Care Director. For more information about this right, see 45 C.F.R.164.526.
- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in writing on a form provided by the Practice. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to your or your legal representative, or any other individual involved with your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes.
- You have the right to obtain a paper copy of our Notice of Information Practices upon request.
- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

For More Information or to Report a Concern

If you have questions and would like additional information, please contact the Patient Care Director.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by the Practice. The complaint form may be obtained from the Practice Administrator, and when completed, should be returned to the Administrator. You may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint.

<u>Our fees as related to services:</u>

Please INITIAL the following:

☐ We schedule consultations for our practitioners with the following format, e.g.: 1-Hour consultation is approximately 45 minutes of face-to-face time, and approximately 15 minutes in administration time for personalized health planning.

The hourly rate for consultations with Dr. Herskowitz is $1,000; The hourly rate for consultations with Dr. Lee and Dr. Joslyn is $500. Consultation fees are charged according to the amount of time spent by the practitioner and administrative time spent reviewing e.g., laboratory results or other records; these charges include email, telephone, internet platforms, video, and in-person. For further review of our consultation fees, please see "Our Services" brochure. Once the patient is scheduled, our practice assumes agreement and the fees.

☐ New patient consultations usually consist of a 90-120 minute consultation with Dr. Lee and Dr. Joslyn. If a new patient is to see Dr. Herskowitz at the first visit, it is usually required that the patient see Dr. Lee or Dr. Joslyn for a 90-120 minute consultation first, followed by a 60-90 minute consultation with Dr. Herskowitz. Follow up consultations that pertain to lab reviews are typically scheduled with Dr. Lee or Dr. Joslyn for a minimum of 60 minutes.

☐ Our consult rates may change without notice based on inflation and other factors.

☐ New Patients are also subject to a separate $200 Record Review administration fee per practitioner for the Practitioner's time of reviewing medical records and new patient paperwork prior to a New Patient's first appointment.

☐ Our office ideally has a New Patient complete laboratory testing prior to the first appointment, and in this case, our office will charge a separate $300 administration fee for preparing these lab testing requisition orders and coordinating with patients and labs to have this completed.

☐ For the patient's convenience, we are also able to coordinate a mobile phlebotomy service for an administration fee of $200 for each coordination. The blood will be drawn at the location of the patient's request. Please note, that both of these fees are non-refundable.

☐ Any follow up appointments including phone, email, video, or in-person will be treated as a consultation and will be charged for as such. Follow-up consultations will be scheduled with Dr. Lee to review laboratory results, and will be subject to the same consultation fees.

☐ I consent to having telemedicine (aka telehealth) consultations, sometimes that include Telephone or Texting and other online meeting platforms. I understand that with these types of communications, there is a small chance that my health information will not be secure as e.g., through the Anatara portal despite reasonable precautions the Practice takes. I also understand that there are limitations in these types of settings for optimal health assessments, and I agree to these types of conditions in order to communicate with the Practice, and participate in my healthcare.

☐ We do typically perform an in-office blood draw after consultations as recommended by our practitioners or prior to receiving an IV therapy. When we perform blood draws, there is a $30.00 charge for this in-office convenience.

☐ Any specialty and at-home test kits given to a patient will also be $20.00 per kit.

☐ Laboratory services are sent with a patient's health insurance if they have, and the laboratory will send a patient an invoice directly for payment once the lab has connected with the patient's insurance company. If the patient has no health insurance, HMO or Medi-Cal, the patient is considered "Self-Pay" in our office and will be charged upfront at the time of the lab draws.

☐ For new patients, or follow-up consults, IV therapies and a blood draw are usually proactively scheduled after their consultation—IV therapy costs range from ~$350-$1,200+. For every IV appointment, there is a $500 minimum charge, even if the Team is unsuccessful at accessing my vein to start my IV.

☐ All fees are collected at the time services are rendered. We are out-of-network, and do not accept insurance for payments. Please note, since the Practice is considered integrative medicine, nearly all of our services are not reviewed nor approved by the FDA. In addition, since we are not primary care, we do not complete any type of disability related forms.

If you ever have any questions regarding estimated costs or service charges, please reach out to our staff.

Name:

Relation to Patient (if signed by legal representative):

Date:

Signature