Liberate Physician Centers - Patient Agreement

I HEREBY AUTHORIZE the doctor(s) provided through Liberate Physician Centers in Florida and other locations (including house calls), and related doctors, healthcare professionals and support staff who may be involved in my care at these locations, to provide care and treatment considered necessary or advisable by the doctor(s).

I understand that by signing this form I am providing the doctor(s) and other healthcare professionals and support staff at Liberate Physician Centers a "general consent" for treatment, care, physical exam, diagnosis, administration and/or other services, and that my decision to seek care at this location is not based upon any understanding, representation or advertisement that the doctor(s) treating me are employees, agents or apparent agents of any hospital. I further understand that I may request that my own doctor receive a copy of any records that result from my visit(s) to Liberate Physician Centers.

I authorize the physicians and other health care professionals and staff members who care for me to perform and/or order diagnostic procedures and to provide such medical treatment as necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees as to the outcome of any procedures, treatments or examinations have been made to me.

I understand that (a) it is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professionals to the patient's satisfaction, (b) each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course, and (c) no patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

I understand and agree to each of the following:

- The patient is here at the request of their treating physician or by self-referral.
- There is no guarantee made that the patient will or will not be certified for medical marijuana, and that the results of the visit are solely based on the evidence provided and the judgment of the certifying physician.
- All statements, records and answers given to the staff and physician by the patient and/or their representative will be truthful and complete. The patient understands and represents that they have a primary physician to treat their conditions, or will obtain one within 30 days. A report will be provided to the patient to give to their primary physician concerning the findings and recommendations of the certification physician, if requested by the patient.
- In the event the underlying condition ceases to be a debilitating condition then the patient agrees to notify the certifying physician immediately.
- Copies of the patients medical records, their certification/application and findings/recommendation letter will be retained by Liberate in the patient's chart during the period the recommendation is in effect and may be kept longer at the option of the clinic and/or physician.
- The doctor/patient relationship is limited to the appropriateness of certification and the patient agrees that medical follow-up will be provided by the primary care physician. At the time of certification, the patient acknowledges the receipt of a follow-up survey to provide Liberate with feedback and allow them to monitor the effectiveness of this treatment. The patient agrees to mail-in follow-up surveys as directed. The patient agrees to, minimally, have a follow-up appointment with

the certifying physician at least once per year or more frequently as directed by the certifying physician. The patient acknowledges and agrees that physician fees must be paid as part of the required follow-up and ongoing care.

- In the event a legal issue arises as to the appropriateness of the certification, the certifying physician will be available to testify if required. Professional witness fees must be paid prior to testimony or the physician is deemed released from this obligation.
- HIPAA confidentiality is maintained and patient agrees to release any and all records relating to the claimed qualifying diagnosis from their treating/primary physician. This includes all records related to HIV/AIDS, drug use, mental conditions and any other conditions.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby authorize payment of insurance benefits otherwise payable to me to be paid directly to the doctor(s) at Liberate. I understand that I am financially responsible for the charges not covered by my insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that the doctor(s) at Liberate provide to the insurance payers, including Medicare, which have been identified as being responsible for payment for medical services received, any information that is necessary to determine whether my care is medically necessary, or which is needed to process payment of my bill, and specifically includes the release of information for utilization review or assessment purposes. This authorization extends to any organization acting on behalf of or in the place of the insurance companies. I understand that information that is released may include my entire medical record including reference to laboratory and other tests results including but not limited to blood alcohol, hepatitis, HIV and other communicable disease testing. I understand that my medical record may contain information related to:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
- Psychiatric Care
- Treatment for alcohol and/or drug use/abuse

ASSUMPTION OF RISK AND FEES

I am aware of the dangers and the risks associated with medical care and treatment. In addition, should I receive a recommendation for medical marijuana therapy:

- I acknowledge having been given information about this therapy and the opportunity to ask questions about the therapy and the Florida program.
- I understand that this therapy is not required and is elective in nature.
- If I receive a recommendation for medical marijuana therapy, I agree to return to the doctor(s) and Liberate at least once per year and more frequently if directed for follow-up care.
- I agree to complete and return any questionnaires and/or medical surveys requested of me by the doctor(s) and Liberate. I also agree to pay, in cash, a $150 fee to Liberate for any appointments I fail to attend, and a $100 fee for any NSF check presented.
- I understand that this activity/therapy involves certain risks for physical injury, both known and unknown, and that there are potential risks of which I may not presently be aware. Because of the dangers of participating in this activity/therapy, I recognize the importance and agree to fully comply

with all applicable laws, policies, rules and regulations, and any medical instructions regarding participation in this therapy.

In consideration for receiving a medical marijuana evaluation, as well as for any and all medical care, treatment, diagnostics and/or other services provided irrespective of whether or not I receive a medical marijuana recommendation, on behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I forever:

1. waive, release, and discharge the doctor(s) and Liberate and its agencies, officers, and employees from any and all negligence and liability for my death, disability, personal injury, property damages, property theft or claims of any nature which may hereafter accrue to me, and my estate as a direct or indirect result of my participation in the above referenced activity or event; and
2. defend, indemnify, and hold harmless the doctor(s) and Liberate Physician Centers, its agencies, officers and employees, from and against any and all claims of any nature including all costs, expenses and attorneys fees, which in any manner result from my care, treatment or other service provided by the doctor(s) and Liberate, or by my participation in any state-approved medical marijuana therapy program, and
3. Agree that Any controversy or claim arising out of or relating to this Agreement or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules. The number of arbitrators shall be one. The place of arbitration shall be the state of Florida. Florida law shall apply. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

I affirm that I am at least 18 years of age and am freely consenting to this Agreement. I have read this form and fully understand that by indicating my acceptance of this form I am giving up legal rights and/or remedies which may otherwise be available to me regarding any losses I may sustain as a result of my participation. I agree that if any portion is held invalid, the remainder will continue in full legal force and effect.

Patient Name: _____

Patient Signature: _____

Date: _____