Xena Health, LLC
9017 S. Pecos Road, Suite 4530
Henderson, Nevada, US - 89074

2. Patient Consent & Clinic Policies

General Consent for Evaluation and Treatment

Welcome to XENA HEALTH, LLC. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

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.

I voluntarily request a medical provider to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

By signing this form, I certify:

• That I have read or had this form explained/read to me and I understand its contents.

• That I have had the opportunity to ask questions and have had them answered to my satisfaction.

I have read, understand and agree to all of the above statements.

PATIENT NAME: * _____

PATIENT SIGNATURE: * _____

DATE: * _____

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Consent For Telehealth Consultation

I understand that I am voluntarily engaging in a telemedicine consultation with XENA HEALTH, LLC.

I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with XENA HEALTH, LLC and to seek out an in-person evaluation with XENA HEALTH, LLC or elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.

I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through XENA HEALTH, LLC will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.

Telemedicine services offered through XENA HEALTH, LLC are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.

To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

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By signing this form, I certify:

• That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.

• That I have had the opportunity to ask questions and have had them answered to my satisfaction.

I have read, understand and agree to all of the above statements.

PATIENT NAME: *

PATIENT SIGNATURE: *

DATE: *

Clinic Policies

I understand that payment for all services rendered must be paid for at the time of service. I understand that there are no refunds for services or products rendered. *

☐ I Agree

I understand that health insurance is not accepted for services provided at XENA HEALTH, LLC. If I want to seek insurance reimbursement, I may request an itemized invoice that I can submit to my insurance company. *

☐ I Agree

I understand that it is important to have lab work monitored regularly for safety purposes. I understand that lab fees are not included in monthly memberships. If desired, I may utilize insurance for processing of my lab work. *

☐ I Agree

I understand that it is my responsibility to call the clinic if an appointment must be cancelled or rescheduled at least 1 full business day prior to my scheduled appointment. I understand that failure to show up for my appointment will result in a $50 fee. *

☐ I Agree

I understand that if I am more than 10 minutes late to my appointment, I may be asked to reschedule and subject to a $50 fee. However, XENA HEALTH, LLC will make every attempt to accommodate my appointment time if possible. *

☐ I Agree

I understand that if on a membership plan, I must maintain my monthly follow up appointments to remain on treatment. If more than 45 days lapses since my last visit without prior arrangement with staff, I will be considered as dropping out of my membership. If I would like to resume progress on my treatment plan, then a “re-start” fee of $100 will be required in addition to the next month’s membership fee. *

☐ I Agree

I understand that if on a membership plan, and if more than 60 days lapses since my last visit then I will need to completely restart my treatment with an initial consult and baseline lab work re-accomplished. *

☐ I Agree

I agree that I will take my medications as prescribed and follow my medical providers instructions. I will not sell or share my prescriptions to other individuals. I understand that used medications cannot be accepted back to the clinic once they have been dispensed per state regulation. *

☐ I Agree

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I agree that if I am having any treatment side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department. *

☐ I Agree

I have read, understand and agree to all of the above statements.

PATIENT NAME: * _____

PATIENT SIGNATURE: * _____

DATE: * _____