PATIENT ACKNOWLEDGMENT AND CONSENT TO TREAT FORM

Authorization for Medical, Health, Hypnosis and/or Nutrition Services: Pursuant to this Client Registration Agreement, I/we authorize Alexandra Johnson, MD to administer such medical, health care and/or nutrition services, treatments and procedures for me or my family members as she deems appropriate and necessary under the applicable circumstances. I/we understand that she will prescribe an integrative program that may include conventional health care, nutritional therapies, functional medicine, bodywork and other elements of integrative medicine. I/we 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/we understand that there are no warranties, representations or assurances of successful outcomes for me or my family members. Nevertheless, I desire to pursue integrative medical treatment or nutrition services for myself or my family members after reviewing the information herein and receiving answers to any questions related to this Agreement. As a patient or family member seeking medical, health care and/or nutrition services, I/we understand that I/we are ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services). I/we will report to Alexandra Johnson, MD any matters arising out of treatments or services and schedule a consultation to conduct appropriate follow-up. I/we will promptly seek medical attention from Alexandra Johnson, MD or another medical facility if any of us experience any unanticipated effects associated with treatments and services or if the treated condition worsens. If a medical emergency arises, I/we will call 911 or visit the nearest hospital emergency room. I/we understand that Alexandra Johnson, MD provides a consultation-only service and does not have urgent care or on-call duties.

Appointments and Cancellation Policy: I/we understand that Alexandra Johnson, MD's time is reserved exclusively for my/our care for the duration of all scheduled visits. I/we understand that I/we are expected to keep all appointments as scheduled in order to ensure maximum progress in connection with treatment and care and that if I/we are late for an appointment, the visit will end at the scheduled time and I/we will be responsible for the cost of the full visit. If I/we need to cancel or reschedule an appointment, I/we will call during business hours at least two business days in advance. No charge will apply in this situation. As an illustration, if an appointment is on a Monday, canceling during business hours on the prior Thursday provides two business days notice. I/we understand that if I/we cancel an appointment during business hours only one business day prior to the scheduled visit, or if I/we fail to show or cancel on the day of the appointment, I/we will be charged a fee equal to 50% of the cost of the scheduled appointment.

Telephone and Email Consultation Policy: Alexandra Johnson, MD checks telephone, patient portal and email messages during business hours and responds to them on a regular basis throughout the week. Non-Urgent messages only, and please allow up to 2 working days for response. I/we recognize that email is not a secure form of message, and I/we are strongly encouraged to use the patient portal for non-urgent medical questions or questions containing personal or medical information. If your questions and/or concerns are more complex, a follow-up appointment may be requested, and you will be responsible for the standard follow-up fees. I/we authorize this to be charged to the credit card on file. If you are experiencing a medical emergency, please call 911 or go directly to an emergency room. In general, Alexandra Johnson, MD does not follow-up with telephone messages, patient portal communications and/or emails that occur after hours, on weekends or holidays. You will not be charged for brief and uncomplicated email or patient portal questions questions. However, I/we understand and agree that where one or a series of emails is in lieu of an in-person or phone consultation, I/we will be billed at the current in-person consultation rate, which I/we authorize to be charged to the credit card on file. By sending an email or patient portal question, I/we acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I/we will not use email communications to deal with emergencies or other time sensitive issues. I/we also understand and agree that email communications (outside of the secure patient portal) may not be secure and the confidentiality of emails cannot be assured or guaranteed, but agree that this is my/our risk with respect to all email communications. Alexandra Johnson, MD may keep copies of email communications, and such messages may be included in the health record.

Insurance Responsibility and Claims Management: I/we acknowledge that Alexandra Johnson, MD strongly recommends that all patients maintain health insurance coverage. It is my/our responsibility to know my/our plan benefits and to obtain insurance advice from my/our own licensed insurance agent, broker or human resource professional. Given the uncertainty that pervades insurance decisions, I/we agree that Alexandra Johnson, MD is not responsible for any information related to my/our insurance that turns out to be incorrect. I/we agree that Alexandra Johnson, MD is not obligated to take action on my/our behalf against an insurance company related to any insurance claim or payment. I/we understand that I/we will receive a superbill or claim form showing the cost and nature of services and it will be my/our responsibility to submit the claim to the insurer. I/we understand that Alexandra Johnson, MD does not participate in insurance plans or accept assignment from any other payer including employers or insurers. I/we will be responsible for all charges and fees incurred for treatments or services rendered, even if my/our insurance company determines that any services are non-covered or excluded. I/we understand that insurance reimbursement may not be available for some services. My/our insurer may not pay for office visits, telephone consultations or emails including but not limited to circumstances where the focus of the consultation is on prevention, education, wellness, nutrition advice, herbal medicine, etc. Some of the lab tests that are ordered, particularly those

that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed.

Financial Responsibility and Authorization for Payment: I/we understand that payment for all services, treatments, products and other fees will be required at each visit and after each other service related matter and authorize Alexandra Johnson, MD to charge all outstanding balances to my/our credit card indicated below. I/we authorize this credit card (and all substituted credit cards) to be used to guarantee and pay for late cancellations, missed appointments, and/or unpaid balances including those related to office visits, telephone/e-mail consultations, charges for products and supplements and miscellaneous costs. I/we agree that if the credit card on file does not accept the charge, I/we will immediately make payment to Alexandra Johnson, MD for the amount due and will provide an alternative Visa/MasterCard account number upon request if my/our current credit card account is over limit, canceled or expired. I understand that fees may increase periodically based on costs relevant to the medical practice.

Health Information Release Authorization and Privacy Practices: Alexandra Johnson, MD is permitted by applicable federal and state privacy laws to use and disclose your protected health information (PHI) for treatment, payment and health care operations and for other purposes as required or permitted by law. Our Notice of Privacy Practices, as it may be amended from time to time (" Notice of Privacy Practices"), is available on the website, by mail upon request or in person at the office. I/we authorize Alexandra Johnson, MD to release my/our medical records in connection with treatment, payment for services and its health care operations and as provided in the Notice, which is incorporated into this Agreement by reference. I/we understand that the Notice may be modified or amended on the basis described in the Notice. I/we also authorize any physician or health care provider to release their protected health information records to Alexandra Johnson, MD. This authorization extends to my protected health information records, if applicable.

Complaints, Comments and Questions: Alexandra Johnson, MD is committed to providing quality care and resolving favorably any complaint, problem, question or unsatisfactory experience that might occur in connection with medical or nutritional services. It is Alexandra Johnson, MD's policy that (i) if any person has a complaint or problem or unsatisfactory or negative experience related to our business, services or products, such person must bring the matter to our attention privately, by email, phone or in person; and (ii) she will investigate any such matter and attempt in good faith, without any retaliation, to reasonably resolve the matter. By signing this Agreement, I/we agree to comply fully with this policy. This is my/our sole and exclusive remedy in connection with any complaint or problem or unsatisfactory or negative experience that I/we may have with Alexandra Johnson, MD's practice, services or products (other than remedies available in a court of law or pursuant to arbitration). I/we

further agree not to publish, post, transmit, disclose or distribute (directly or indirectly), in or on any publicly available or accessible forum, newspaper, magazine, electronic publication, blog, web site, on-line users group or similar device, document or medium, any negative, false or disparaging comment, belief, opinion, experience or information (or that could reasonably be so construed), without prior written consent. I/we acknowledge and agree that these terms are reasonable and that any breach or violation of this paragraph will cause significant damage and expense that would be impossible or highly impractical to quantify and establish. Consequently, I/we agree that upon each breach or violation of this paragraph, I/we will be obligated, jointly or severally, to pay liquidated damages in the amount of $200.00 per day per violation until the breach or violation has been cured to satisfaction.

Duration of Agreement, Revocations of Authorizations and Amendments: I/we may revoke the medical records release authorization in writing at any time and Alexandra Johnson, MD will attempt to accommodate all reasonable requests. However, I understand that in some circumstances related to treatment, payment or health care operations, Alexandra Johnson, MD 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, cancelation or termination of this Agreement for any reason. I/we also certify that my family or 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, reflects 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 Alexandra Johnson, MD and each of the undersigned.