ALLUVION
HEALTH

INFORMATION PRIVACY: I acknowledge receipt of Alluvion Health's Notice of Privacy Practices. ALLUVION HEALTH's practitioners and staff will use and disclose your personal health information to treat you, to receive payments for the care we provide, and for other health care operations.

OWNERSHIP INTERESTS: Alluvion Health has an ownership interest in Adlera Laboratory, LLC. As a patient, I acknowledge that I have a choice in where I receive my lab work and will notify my provider of that choice when asked. You also have the right to ask your provider if there is another facility qualified to carry out their instruction. If you have concerns or questions about the financial relationship between Alluvion Health and Adlera Laboratory, please ask before signing this document.

IMMUNIZATION CONSENT: I give consent for any vaccination information to be entered into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to my health care providers, child care facilities, and schools in which my child/myself are enrolled. I understand that I can revoke this authorization and have the record removed at any time by contacting ALLUVION HEALTH.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge receipt of Alluvion, Inc.'s Patient Rights and Responsibilities outlining my rights as a patient and my responsibilities as a patient of ALLUVION HEALTH.

PRESCRIPTION HISTORY: I authorize and give consent for ALLUVION HEALTH to obtain my prescription history from external sources.

CONSENT TO TREATMENT: By presenting for treatment, I consent to any routine services and diagnostic procedures that may be necessary. If I leave without consent of the provider/physician, I will be liable for the consequences of such decision.

AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT: I have provided complete and accurate demographic information and insurance billing information, allowing Alluvion Health to act as my billing agent for services rendered. The undersigned agrees to "assign" to ALLUVION HEALTH all insurance benefits available for any professional and clinic services rendered within ALLUVION HEALTH, payable directly to ALLUVION HEALTH. The undersigned agrees to promptly pay for any charges or residual insurance balances (within 30 days) unless other arrangements have been made. Should balances not be paid, pursuant to ALLUVION HEALTH's billing and collection policies and procedures, the undersigned understands that his/her account may be assigned to a financial institution with whom ALLUVION HEALTH has an accounts receivable management contract. Should the account be placed for outside collections, the undersigned agrees to pay all fees and collection expenses. Should the account be referred to an attorney for collection, the undersigned agrees to pay attorney fees reasonable with all costs and expenses incurred. The undersigned agrees that the venue of any lawsuit shall be in the County of Cascade, State of Montana.

CONSENT TO FOLLOW-UP: In order to improve patient services, I may be contacted regarding the care I received. Should I choose to respond to questions, any information I provide will be held in confidence.

CONTINUING EFFECT: In order to shorten the registration procedures for any future visits which I may make, I hereby acknowledge and agree that these Conditions and my Consent of Treatment will remain in effect unless they are revoked by me in writing.