Green Health Consultants

GREEN HEALTH CONSULTANTS

PATIENT CONSENT FOR TELEHEALTH SERVICES

I hereby request, consent and authorize Green Health Consultants and its subsidiaries, affiliates and agents (collectively, the "Company") and their employed or contracted nurse practitioners, registered nurses or other licensed health care professionals (the "Professionals"), to utilize Tele-health methodology through the Company's systems and protocols to access, consult, and educate myself and those I am authorized to represent (the "Services").

The Services

- ✓ I understand that the Professionals will make every attempt to accurately access, and educate and provide guidelines for treatment regarding the health care condition and medical cannabis for which I or those I am authorized to represent present to the Company or the Professionals.
- ✓ I understand that the service fees due to the Company DO NOT include the costs of any treatment, procedure, service, or medicine recommended by the Company or the Professional.
- ✓ I understand that once the Professional suggests a treatment, procedure, service or product, if any, it is my responsibility to read and understand the risks and the potential side-effect profile and the adverse drug interactions of the medications and any other medications I may be taking concurrently, or consult with my primary care or specialty physician and pharmacist regarding the same, and ultimately to determine if I accept the risks.
- ✓ I understand that all health care treatments can have potential adverse side effects and I accept responsibility for such potential adverse outcomes. If adverse effects are noted, I understand that it is my responsibility to stop any treatment, procedure, service or product recommended by the Company or the Professional, and to report any adverse side-effects to the Company, the Professional, my primary care or specialty physician, or go to the nearest Emergency Room if I have any reason to suspect that I have a medical emergency.
- ✓ I acknowledge that the Professionals shall exercise reasonable medical judgment in delivery of the Services provided, if any, but the condition for which I or those I am authorized to represent may seek a consultation or treatment may worsen after the Service provided, and both I and those I am authorized to represent are subject to the risks described above, including risks that the condition may worsen. I agree that I will not be entitled to a refund or recompense from Company or the Professionals for any reason, including poor outcomes.
- ✓ I WILL INFORM THE COMPANY OR THE PROFESSIONAL OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO RECEIVE THE SERVICES PROVIDED OR THAT WOULD BE RELEVANT TO THE SERVICES THEMSELVES. IN PARTICULAR, I UNDERSTAND THAT IF I AM PLANNING TO BECOME PREGNANT, AM CURRENTLY PREGNANT, BECOME

PREGNANT, OR AM BREASTFEEDING, THAT I WILL: (A) ADVISE COMPANY AND THE PROFESSIONALS OF THIS FACT; AND (B) ASK MY OB/GYN OR PEDIATRICIAN IF THE TREATMENTS RECOMMENDED BY THE PROFESSIONALS ARE ACCEPTABLE DURING THIS PERIOD OF TIME.

- ✓ I understand that it is my sole responsibility to communicate and provide the Company and the Professionals with accurate and complete information concerning medical, medication and other history, allergies to medications and procedures, physical, mental and other relevant symptoms and conditions, and any other information or records requested or pertinent to the treatment of myself or those I am authorized to represent. I assume all risks, and assume full responsibility and waive all claims against the Company and the Professionals for personal injury, death or damages of any kind and agrees to the extent permitted by applicable law to defend, indemnify and hold harmless the Company and the Professionals from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from the failure to provide pertinent information and/or the failure to provide accurate and/or complete information as required.

Limited Nature of Relationship

TO THE EXTENT ALLOWABLE BY LAW, THE SERVICES PROVIDED, IF ANY, ARE NOT INTENDED TO CREATE, NOR DO THEY CREATE, ANY PRACTITIONER-PATIENT RELATIONSHIP WITH THE COMPANY OR THE PROFESSIONALS, EXCEPT WITH THE PROFESSIONALS, FOR THE LIMITED PURPOSES OF PROVIDING THE SERVICES.

I AGREE THAT NEITHER THE COMPANY NOR THE PROFESSIONALS HAVE AN OBLIGATION TO ACCESS, CONSULT, TREAT OR EDUCATE ME REGARDING ANY CONDITIONS BEYOND WHAT MAY BE DISCLOSED, DISCOVERED, EVALUATED OR DISCUSSED DURING THE SERVICES PROVIDED.

Telehealth

I understand that I have the option to withhold or withdraw my consent to receive the Services via Telehealth at any time, but that doing so will cause the Company and the Professionals to discontinue providing subsequent Services.

I understand that federal and state laws concerning the confidentiality of person health information apply to services delivered and information acquired via Telehealth, including patient access and amendments to medical records. I understand that in rare circumstances, security safeguards and protocols could fail causing a breach of patient privacy.

I have read and understand the written information provided above. I agree that the information provided above adequately explains the Services, along with the risks and benefits of said

Services. I have had the opportunity to ask questions about this information – if I had any questions, all of my questions have been answered in full by the Company. By electronically signing this form, I acknowledge and agree to all of the above, and certify that I have no questions and/or have had my questions answered in full.

NAME _____

SIGNATURE _____

DATE _____