MEDICAL/WOUND CARE INFORMED CONSENT

I, (patient)_____, or_____ as Patient Guardian/Representative (acting on his/her beha10, hereby authorize "Keturah Health" to provide me with necessary services, treatments and diagnostic tests; to include any examinations, X-rays, laboratory procedures, tests, medications, medical treatment, sharp debridement, biopsies and/or other services rendered by the attending physician or other treating practitioners and their associates. I understand that this Consent Form will be valid aid remain in effect from the date of signature, as long as Patient receives care, treatment and services from Keturah Health multispecialty healthcare clinic.

Medical Services: I recognize that the practice of is not an exact I understand that no guarantees have been made as to the results from the treatment and care rendered by the assigned healthcare providers. I hereby voluntarily consent to outpatient care from Keturah Health encompassing routine diagnostic procedures, examination, routine laboratory work including HIV testing, examination and cosmetic procedures such as Laser treatments, botox, dermal filler, microneedling, and body contouring among others offered in the clinic.

Wound Care Services: Wound care treatment may include, but shall not be limited to: sharp debridement, dressing changes, biopsies, skin graph, off-loading, Negative Pressure therapy and compression devices. Risks/Side Effects. May include, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood or surrounding areas such as organs and nerves, bleeding, allergic reaction to medications, removal of healthy tissue, prolonged healing or failure to heal.

Patient understands and consents to images (digital, film, etc.). Images may be taken of Patient and all Patient's wounds or cosmetic procedure with their surrounding anatomic features. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that Keturah Health will retain the •ownership rights to these images, but that the patient will be allowed access to view them or obtain copies. Patient understand that these images will be stored in a secure manner that will protect privacy and that they will be kept for the period by la., Patient waives any and all rights to royalties or other compensation for these images. Image that identify the Patient will only be released and/or used outside the Keturah Health upon written authorization from the Patient or Patient's legal representative.

Use and Disclosure of Protected Health & Information (PHD: Patient consents to Keturah Health use of PHI, results of patient's medical history and physical examination, wound images obtained during Patient's procedures and stored in the Keturah Health for purposes of, education, research, quality management activities, ongoing analysis, data aggregation and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by Keturah Health to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPPÄ).

Financial Responsibility: Patient understands that regardless of their assigned insurance benefits, Patient is responsible for any amount not covered by insurance. authorizes medical information about Patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services. Patient future understands that payments for cosmetic and weight loss services are non-refundable.

BY SIGNATURE, I ACKNOWLEDGE THAT I HAVE READ THIS FORM IN ITS ENTIRETY, THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTION CONCERNING THE TREATMENT AND/OR PROCEDURE(S). THEMY MY QUESTION HAVE BEEN ANSWERED TO MY SATISFACTION, AND I AGREE TO ITS PROVISIONS AND CONSENT TO THE TREATMENT OR PROCEDURE(S) PROPOSED.

X _____

Patient

Responsible party if patient is unable to sign