3: GENERAL AUTHORIZATION

As a condition of my/guardian's (collectively, "I" or "me") treatment by health care providers associated with Salud Medical and Consulting LLC (collectively, "Salud" or "it"), I agree to the following:

FULL DISCLOSURE

I agree to provide Salud with the accurate and updated information regarding my identity, current location, medical history, possible pregnancy, prescription and non-prescription medications taken, allergies to medications, and other matters that may affect diagnosis and treatment. I permit Salud to access external medical and prescription history information from insurance plans, state prescription drug monitoring programs, retail pharmacies and pharmacy benefits managers.

GENERAL CONSENT FOR SERVICES

I consent to receiving care/services from Salud. This may include, but is not limited to, emergency treatment, examination, diagnostic procedures, acupuncture and/or other therapies, and prescription of drugs and/or nutraceuticals.

CHARGES

I agree to pay all charges incurred in my care in accordance with the published Fee Schedule or such other rates and terms as determined by a contract, insurance policy, or regulation. Such charges include, but are not limited to, any deductibles, co-insurance, co-payments, and non-covered charges. I understand that Salud reserves the right to change its rates at any time. I understand that, regardless of my insurance coverage, I am ultimately responsible for all charges.

ASSIGNMENT OF BENEFITS

I assign to Salud Medical and Consulting LLC all rights, benefits, privileges, claims, causes of action, interests, or recovery receivable by me (or on my behalf) arising out of any policy of insurance, plan, trust, fund, Medicare, Medigap, or Medicaid, or coverage of any type for the services rendered to me, including the right to proceed in arbitration. This includes, without limitation, any private or group health, automobile liability, general liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, self-funded plan, trust, MEWA, collective, or any other third-party payor.

I authorize direct payment to Salud Medical and Consulting LLC of all benefits, payments, monies, checks, funds, wire transfers, or recovery of any kind whatsoever. I agree that any payments of any kind that are sent directly to me (or to another third party responsible for me) will be forwarded to Salud.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I understand that Salud, third party payors, and/or billing companies may obtain, use, disclose, and/or exchange my protected health information for the purposes of treatment, payment, and/or normal healthcare operations. This use and disclosure may include collection agencies and credit bureaus. This information may contain psychiatric, drug abuse, alcohol, and/or HIV status.

I certify that the information provided by me under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries, or its carriers any information related to any Medicare, Medigap, or Medicaid claim.

AUTOMATED AND NON-AUTOMATED PATIENT COMMUNICATION

I hereby expressly consent to allow Salud (and/or business associates/collection agencies) to contact me via cellular telephone, text message (SMS), electronic mail, and/or any other form of electronic communication, including using pre-recorded messages, auto-dialers, and/or other forms of automated/electronic communication. I understand that electronic communication is unencrypted

(unsecure) and can be intercepted in transmission or misdirected and I accept the possible risks associated with such communication. Any communication sent to the email address and phone number I have provided during registration will be effective once delivered, regardless of whether I choose to open/read it.

IMAGES, RECORDINGS, AND ELECTRONIC TRANSMISSIONS
I agree that all forms of electronic communication, including phone calls, telemedicine consultations, texts, emails, photographs, videos, and/or electronic transmissions, may be taken and recorded for patient identification, insurance verification, and care documentation. I may be asked to have a photograph of a limited area of my skin/body taken for the purposes of diagnosis, record-keeping, and consultation with other health care providers. I further agree not to take photographs, make videos or audio recordings during my treatment without prior approval.

RELEASE FROM LIABILITY FOR VALUABLES – OFFICE VISIT
I understand that patients are encouraged to leave personal items at home as Salud does not provide a repository for the safekeeping of valuables. I hereby release Salud from any liability due to loss of, or damage to, or theft of my vehicle and any of my personal possessions, including but not limited to, money, jewelry, clothing, and other valuables, that I choose to bring to my treatment. I further agree not to hold Salud responsible for the loss of, damage to, or theft of my vehicle while receiving treatment. I acknowledge and agree that in no event shall Salud be liable to me for any loss of, or damage to, any of my valuables or personal property more than $100.

RELEASE FROM LIABILITY FOR VALUABLES – HOUSE CALL
I agree not to hold Salud liable for any losses, expenses, damages, and costs, including reasonable attorney fees, resulting from damage to or loss of my personal property. I further acknowledge and agree that in no event shall Salud be liable to me for any loss of, or damage to, any of my valuables or personal property more than $100.

SEVERABILITY
If any provision, paragraph, or part of any paragraph of this General Consent for Services is declared to be unlawful, invalid, or unenforceable for any reason, the remaining terms, provisions, paragraphs, or sections shall remain in full force and effect.

POLICIES AND DISCLOSURES
I had the opportunity to examine the HIPAA Notice of Privacy Practices and Patient Rights and Responsibilities. These documents, as well as the Non-Discrimination Policy, various practice policies, Fee Schedule and any other disclosures required by law, are displayed on www.gosaludmedical.com and may be periodically updated or modified.

I have read or have had read to me this *General Authorization for Services*. I was invited and encouraged to ask questions. I understand and agree with this *General Authorization for Services*. This *Authorization* begins on the date below and remains in effect until revoked in writing. I intend this *Authorization* to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment from Salud.

Print Name: Patient / Responsible party	Sign Name: Patient / Responsible party
Salud	Date