Terms and Conditions for Direct Booking

These Terms and Conditions govern the scheduling and cancellation of appointments with **InMotion Health, P.A.** By making a direct booking, you acknowledge and agree to the following:

1. Service Area for In-Home Visits

In-home visits are available only within our designated service area. Direct bookings must be scheduled at an address located in one of the following zip codes:

33069, 33060, 33062, 33309, 33334, 33308, 33306, 33311, 33305, 33304, 33312, 33301, 33315, 33316

If a direct booking is made for an address outside the listed service area, it will not be honored, and a **25% (twenty-five percent) fee of the normal, predetermined service rate in effect as of the date of the appointment** will be charged.

2. Telemedicine Appointments

Patients utilizing telemedicine services must physically be located within the **State of Florida** at the time of their virtual visit.
If this condition is not met, the appointment will not be honored, and a **25% (twenty-five percent) fee of the normal, predetermined service rate in effect as of the date of the appointment** will be charged.

3. Appointment Location

All in-home visits take place at the patient's home or designated location within the approved service area. **Appointments will never be conducted at the business address listed on the direct booking page.**

4. Eligibility to Book

- You must be at least **18 years of age** to make a direct booking.
- If you are booking on behalf of someone else, please specify this in the **comments section** when booking.

5. Cancellation Policy

- Appointments may be canceled without penalty up to **twelve (12) hours** prior to the scheduled time.
- Cancellations made with less than twelve (12) hours' notice will incur a **cancellation fee equal to 50% (fifty percent) of the normal, predetermined service rate in effect as of the date of the appointment**.
- No-shows will be treated as late cancellations and subject to the same cancellation fee.

6. Fees and Charges

- All service fees are predetermined and current as of the date of the appointment.
- Applicable fees (including ineligible service area charges or cancellation fees) will be billed to the payment method on file or collected prior to making subsequent direct bookings.

7. Agreement

By making a direct booking with InMotion Health, P.A., you acknowledge that you have read, understood, and agreed to abide by these Terms and Conditions.

8. Consent Forms and Privacy Notices

The following consent forms are available for your review and will be collected with your signature prior to your visit via our EHR platform, **Athena Health**:

- General Patient Consent To Treat Form
- Financial Consent Form
    - Cancellation/No-Show Policy Acknowledgment
- HIPAA Notice of Privacy Practices
- Patient Rights and Responsibilities
- Minor Procedures Consent

- Arbitration Patient Agreement
- Home Visit Safety Acknowledgment
- Website - Privacy Policy
- Authorization to Share Medical and Insurance Information with Third-Party Providers for Coordination of Care and Related Billing

INMOTION HEALTH, PA

Patient Financial Consent Form

The following document serves to create an understanding between **INMOTION HEALTH, PA** ("Provider") and **Patient** regarding Provider's financial policy, as it relates to services rendered by its physicians and affiliated healthcare providers. If there are any questions regarding this Financial Policy, please contact our office directly at (954) 228-3019 or email us at contact@inmotionhlth.com to speak with our billing department.

1. Payment for services rendered is due at the time of service, unless other arrangements have been made prior to the visit.
2. Provider accepts the following methods of payment: American Express, MasterCard, Visa, Discover or debit card.
3. Provider does not accept any form of insurance. Provider will not be responsible for contacting Patient's insurance company for reimbursement, but will provide documentation to Patient, within a reasonable time period, upon written request from Patient. Claims to Patient's insurance company may be made by Patient for reimbursement of Provider's services provided by an "out-of-network" provider.
4. Provider will make all reasonable efforts to change or reschedule an appointment. However, a cancellation fee will be charged if the appointment is canceled with less than twelve (12) hours notice to Provider from the scheduled appointment time with Provider. To cancel an appointment, the Patient must notify the Provider by either emailing the practice, calling the practice or using the patient portal. Cancellation requests will only be considered valid once acknowledged by the Provider or a member of the practice staff. Cancellation fee will be equal to 50% (fifty percent) of the normal, predetermined service visit fee, in effect as of the day of the appointment. If the appointment is rescheduled for the same day as the original appointment, n cancellation fee will apply.

I have received a copy, read, understand and agree to this Patient Financial Policy. I agree to be legally bound by its terms. Terms contained herein may be amended by Provider and will be provided to Patient prior to the Provider providing any services to Patient.

INMOTION HEALTH, PA

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ **Date of Birth**: _____

I understand that I am eligible to receive a range of services from InMotion Health, PA and InMotion Health, PA health care providers. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Treatment may be provided over the course of several weeks if follow up is required or deemed necessary.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment. I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with InMotion Health, PA and InMotion Health, PA health care providers.

Maintaining Results:

For continued results, you may require additional Medical Treatments at intervals determined by your treatment provider in conjunction with your personal treatment plan.

I have read and understand I may require future treatment to maintain results. Initials:_____

Financial Responsibility:

I understand the regular charge applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for

payment. I further agree in the event of non-payment, to bear the cost of collection and/or Court costs, fees and reasonable legal fees, should this be required.

I have read and understand I am financially responsible for services rendered. Initials:_____

Disclosure of Health History/Medications/Substance Abuse Use:

I agree to inform the staff of any known allergies to medications, foods and/or other substances and have disclosed any previous allergic reactions. I further agree to inform staff of any/all medications/substances I am currently taking, including recreational or street drugs, and have disclosed all pertinent health history. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications.

I have disclosed all medication, allergy, and health history to staff. Initials:_____

Consent:

By signing below, I acknowledge and agree:

- I have fully disclosed on my Patient Intake Form any medications, previous complications, planned or previous surgeries, sensitivities, allergies, or current conditions that may affect my treatment.
- I have read the foregoing informed consent for Medical Treatment and agree to the treatment with its associated risks.
- I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
- I have received and will follow all aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications.
- I hereby consent to perform this, and all subsequent Medical Treatments, with the above understood. I hereby release the the health care provider performing Medical Treatment, and INMOTION HEALTH, PA and its staff from liability associated with this procedure.
- It has been explained to me in a way that I understand:
    - The above treatment or procedure undertaken.
    - There may be alternative procedures or methods of treatment.

- There are risks, known and unknown, to the procedure or treatment proposed.

- **IF I AM SIGNING ON BEHALF OF A MINOR CHILD, I ALSO GIVE FULL PERMISSION FOR ANY PERSON CONNECTED WITH INMOTION HEALTH, PA, TO ADMINISTER FIRST AID DEEMED NECESSARY, AND IN CASE OF SERIOUS ILLNESS OR INJURY, I GIVE PERMISSION TO CALL FOR MEDICAL AND/OR SURGICAL CARE FOR THE CHILD AND TO TRANSPORT THE CHILD TO A MEDICAL FACILITY DEEMED NECESSARY FOR THE WELL BEING OF THE CHILD.**

_____ _____ _____

Patient Name (Print) Patient Signature Date

IF PARTICIPANT IF UNDER THE AGE OF 18:

Signature of Parent or Guardian:_____;
Date:_____

Parent or Guardian/Print Name:_____

PATIENT ACKNOWLEDGEMENT AND RELEASE

Treatment Liability Waiver

I acknowledge that Medical Treatment(s) may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. Medical Treatment(s) has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the conditions for which you are under treatment and in your overall health.

The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned Medical Treatment(s) to be provided and fully agree to submit to the Medical Treatment.

Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, independent contractors, or employees of INMOTION HEALTH, PA, for any condition or result, known or unknown, that may arise as a consequence of any treatment I may receive.

I understand and agree that any legal action of any kind related to any treatment I received will be limited to binding arbitration pursuant to the Arbitration Agreement.

By signing below, I acknowledge and agree:

I have carefully read the information on this Consent Form and understand I may be giving up some important legal rights by signing.

_____ _____ _____

Patient Name (Print) Patient Signature Date

Signature of Parent or Guardian:_____
Date:_____

Parent or Guardian/Print Name:_____

INMOTION HEALTH, PA

Lab and Imaging Consent Form

Authorization to Share Medical and Insurance Information with Third-Party Providers for Coordination of Care and Related Billing

- Consent for Treatment and Payment:

This is to certify that I consent to and authorize InMotion Health, PA and InMotion Health, PA health care providers to perform specimen collection and analysis of the recommended laboratory tests. I understand, consent to and authorize InMotion Health, PA and InMotion Health, PA health care providers to order any necessary laboratory tests or imaging tests from third party CLIA laboratories or imaging centers. I understand that InMotion Health, PA health care providers, will order, read, and interpret the results. In the given case that abnormal lab values or abnormal imaging results are found, I will be referred to my PCP or a specialist for further treatment and management as deemed necessary. I understand that I have the sole responsibility to take appropriate action on the laboratory and imaging results and consult my PCP/specialist regarding abnormal results. I also agree to take full financial responsibility for the cost of the tests that I request and authorize to be ordered by InMotion Health, PA and InMotion Health, PA health care providers. I also agree to and authorize InMotion Health, PA and InMotion Health, PA health care providers to share my insurance information and medical information, if needed, with a third party certified CLIA Lab or imaging centers.

I understand that I am fully responsible for the fees associated with obtaining specimens, lab costs, imaging costs, ordering, reading and interpreting the labs and imaging by InMotion Health, PA and InMotion Health, PA health care providers. This fee will be given prior to the service being provided. You will access your labs via your patient portal with InMotion Health, PA or through well-known laboratory/imaging companies that will be working with InMotion Health, PA, portals. If a result is deemed “critical”, InMotion Health, PA and InMotion Health, PA health care providers will make every attempt to contact you.

- I have read this form - or had it read and explained to me - in full. I fully understand its content.
- I have been given opportunity to ask questions, and any questions have been answered to my satisfaction.

I hereby give my informed consent to provide specimens for lab testing and fully accept the fees associated with obtaining specimens, lab costs, imaging costs, ordering, reading and interpreting the labs and imaging by InMotion Health, PA and InMotion Health, PA health care providers. I also agree to and authorize InMotion Health, PA and InMotion Health, PA health care providers to share my insurance information and medical information, if needed, with a third party certified CLIA Lab or imaging centers.

By signing below, I acknowledge and agree:

I have carefully read the information on this Lab and Imaging Consent Form.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

INMOTION HEALTH, PA

PATIENT CONSENT TO MINOR PROCEDURES

Patient hereby voluntarily consents to undergo one or more minor procedures performed by INMOTION HEALTH, PA (the "Company"), its licensed health care providers, and their respective employees, agents, representatives, and affiliated companies (collectively referred to as "Provider"). This consent applies to all minor procedures offered by the Company, including but not limited to Laceration repair (sutures, staples, skin glue), Incision and drainage of abscesses or cysts, Wound debridement and dressing changes, Foreign body removal (e.g., splinter, ear foreign body, eye foreign body), Skin lesion biopsy or removal, Hematoma or blister drainage, Suture/staple removal, Ear Irrigation, diagnostic procedures, and other similar treatments. This form remains in effect as long as the Patient receives care from the Company unless revoked. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. General Description of Minor Procedures

Patient acknowledges that Provider has explained that treatment may include, but shall not be limited to: cleaning and preparing the treatment area; administration of local anesthesia; removal of damaged tissue, foreign material, or lesions; closure of wounds with sutures, staples, or skin adhesive; drainage of fluid or pus from abscesses or cysts; dressing changes; and other related techniques necessary for the care and treatment of the condition.

2. Benefits of Treatment

Patient acknowledges that Provider has explained that the benefits of treatment may include: improved healing, relief of pain or discomfort, prevention of further infection, improved function of the affected area, and improved cosmetic appearance.

3. Risks/Side Effects of Treatment

Patient acknowledges that Provider has explained that treatment may cause potential side effects and risks including, but not be limited to: infection, bleeding, swelling, allergic reaction to topical or injected anesthetics or antiseptics, scarring, damage to surrounding tissues, nerves, or blood vessels, pain, delayed healing, recurrence of the original problem, retained foreign material, and in rare cases, systemic infection or sepsis.

4. Likelihood of Achieving Goals

Patient acknowledges that Provider has explained that by following the Provider's plan of care he or she is more likely to have a better outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Therefore, Patient specifically agrees that no representation made to him or her by Provider, or the Company constitutes a Warranty of Guarantee for any result or cure.

5. Alternatives to Treatment

Patient acknowledges that they have been made aware that they may refuse treatment. Patient acknowledges that if they refuse treatment they will not gain the benefits of treatment (see Benefits of Treatment above). Alternatives may include: observation with no intervention, at-home wound care, oral

or topical medications, or referral to another healthcare provider for further evaluation. Declining treatment may result in worsening of the condition, prolonged healing, increased pain, or infection.

6. Benefits of Alternatives
Patient acknowledges that Provider has explained that potential benefits of declining or delaying treatment include avoidance of the risks and side effects associated with the procedures (see Risks/Side Effects of Treatment above).

7. Risks of Alternatives
Patient acknowledges that Provider has explained that the risks of alternative wound care treatment include prolonged healing or failure to heal, infection or progression of infection and possible amputation if wound is on a limb, worsening of symptoms, tissue damage, or more complicated treatment requirements later.

8. Patient Identification and Procedure Images
Patient understands and consents that images (digital, film, etc.), may be taken by INMOTION HEALTH, PA, to document the procedure for medical records. The purpose of these images is to monitor the progress of treatment and ensure continuity of care. 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 protected health information (PHI) and will be handled in accordance with HIPAA regulations, federal laws regarding the privacy, security and confidentiality of such information. Patient understands that the Company will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies according to state and Federal law. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law and/or state policy. Patient waives any and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside of the Company upon written authorization from the Patient or Patient's legal representative.

9. Use and Disclosure of Protected Health Information (PHI):
Patient consents to the Company's use of PHI, results of patient's medical history and physical examination, and wound images obtained during the course of Patient's wound care treatment and stored in the Company's wound database for purposes of, education, research, quality assessment and improvement activities, and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by the Company 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 (HIPAA). Patient specifically authorizes the use and disclosure of patient's PHI by HI, its affiliates, and business associates for purposes related to treatment, payment, and health care operations. If Patient wishes to request a restriction to how his/her PHI may be used or disclosed, Patient may send a written request for restriction to the Company. If the PHI is owned by a Home Health Agency or another entity/facility, the Company will direct Patient's request to the appropriate party.

Maintaining Results:

For continued results, you may require additional Treatments at intervals determined by your treatment provider in conjunction with your personal treatment plan.

I have read and understand I may require future treatment to maintain results. Initials:_____

No Guarantee of Results:

I some situations, it may be possible to achieve optimal results. Should complications occur, additional or other treatments may be necessary.

I have read and understand results are not guaranteed. Initials:_____

Financial Responsibility:

I understand the regular charge applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection and/or Court costs, fees and reasonable legal fees, should this be required.

I have read and understand I am financially responsible for services rendered. Initials:_____

Disclosure of Health History/Medications/Substance Abuse Use:

I agree to inform the staff of any know allergies to medications, foods and/or other substances and have disclosed any previous allergic reactions. I further agree to inform staff of any/all medications/substances I am currently taking, including recreational or street drugs, and have disclosed all pertinent health history. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications.

I have disclosed all medication, allergy, and health history to staff. Initials:_____

Consent:

By signing below, I acknowledge and agree:

- I have fully disclosed on my client intake form any medications, previous complications, planned or previous surgeries, sensitivities, allergies, or current conditions that may affect my treatment.
- I have read the foregoing informed consent for Intramuscular Injection Therapy and agree with the treatment and its associated risks.
- I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

- I have received and will follow all aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications.
- I hereby consent to perform this, and all subsequent Intramuscular Injection Therapy, with the above understood. I hereby release the physician, the health care provider performing Intramuscular Injection Therapy, the health care provider, and INMOTION HEALTH.
- It has been explained to me in a way that I understand:
    - The above treatment or procedure undertaken.
    - There may be alternative procedures or methods of treatment.
    - There are risks, known and unknown, to the procedure or treatment proposed.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Witness Name (Print)	Witness Signature	Date

CLIENT ACKNOWLEDGEMENT AND RELEASE

Treatment Liability Waiver

I acknowledge that elective supplementation therapies, including but not limited to Laceration repair (sutures, staples, skin glue), Incision and drainage of abscesses or cysts, Wound debridement and dressing changes, Foreign body removal (e.g., splinter, ear foreign body, eye foreign body), Skin lesion biopsy or removal, Hematoma or blister drainage, Suture/staple removal, Ear Irrigation, diagnostic procedures, and other similar treatments, may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the conditions for which you are under treatment and in your overall health. Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment providers and staff at INMOTION HEALTH, PA.

I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me.

Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, independent contractors, or employees of the above referenced companies for any condition or result, known or unknown, that may arise as a consequence of any treatment I may receive.

I understand and agree that any legal action of any kind related to any treatment I received will be limited to binding arbitration pursuant to the Arbitration Agreement.

By signing below, I acknowledge and agree:

I have carefully read the information on this Consent Form and understand I may be giving up some important legal rights by signing.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Witness Name (Print)	Witness Signature	Date

INMOTION HEALTH, PA

Acknowledgement of Privacy Practices

I,_____, acknowledge that INMOTION HEALTH, PA ("Provider") has provided me with a copy of Provider's Privacy Practices. This document provides information about how protected information about me and my health conditions.

I,_____, acknowledge that I have been offered an opportunity to review the Provider's Privacy Practices before signing this consent form and that I have received a copy of the Provider's Privacy Practices. I understand that I have the right to review the notice prior to signing this consent. I have the right to object to the use of my health information for directory purposes. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. Moreover, I understand that the Provider is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Provider has already taken action, in reliance thereupon.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Name of Patient/Authorized Representative (Print) Relationship to Patient

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Sharing of Health Information with Other Providers

I,_____, acknowledge that my medical information may be shared with other providers who may care for me during any point in the future, from the date of this contract forward. I understand that to provide a continuity of
care, that Provider may have to disclose information in various methods of dissemination, including, but not limited to the following methods: email, electronic file transfer, fax, telephone conversations or in-person discussions. I understand that the Provider will take all necessary steps to honor, respect and protect the Patient's privacy during such communication. I acknowledge that medical information may include sensitive information relating to my health care conditions.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Name of Patient/Authorized Representative (Print) Relationship to Patient

Authorization To Release Medical Records

Patient Information:
Name of Patient (Print): _____
_____
Social Security Number: _____
_____
Date of Birth:_____

Provider Information:
Name of Provider: **INMOTION HEALTH, PA**
Address of Provider: 2881 East Oakland Park Blvd, Fort Lauderdale, FL 33306
Office Number of Provider: (954) 228-3019
Fax Number of Provider: Athena Fax for patient related information (833) 974-4978 or (954) 869-9495 for all other faxes

Medical Information Requested:

( ) All Records
( ) Specific Records from_____to _____
( ) History and Physical Examinations
( ) Immunization Records
( ) Radiology images, EKG and associated reports
( ) Laboratory Tests

This form provides explicit consent from the patient to INMOTION HEALTH, PA ("Provider") to authorize the disclosure of records for one calendar year (365 days), commencing on the date of signature on this document, as signed below. I acknowledge and fully understand that these records are protected under both State and Federal law and cannot be released or disclosed without written consent unless otherwise provided by law.

I,_____understand that the specific type of information to be disclosed to Provider may, if applicable, include the following: diagnosis, prognosis, treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, sexually transmitted diseases, human immunodeficiency virus ("HIV"), autoimmune deficiency syndrome ("AIDS") for any admissions.

I,_____understand that I have the right to revoke this consent at any time. However, I understand that I may not revoke this statement in the circumstance that the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Signature of Patient/Authorized Representative

Dat

Name of Patient/Authorized Representative (Print)

Relationship to Patient

Privacy Policy

NOTICE OF PRIVACY PRACTICES

Effective Date: August 6, 2025

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Practice administrator by dialing the main facility number at (954) 228-3019 or by email at contact@inmotionhlth.com

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you with a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for

educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

To remind you that you have an
appointment for medical care; To assess
your satisfaction with our services;
To tell you about possible treatment alternatives;
To tell you about health–related benefits or services;
For population based activities relating to improving health or reducing
health care costs; For conducting training programs or reviewing
competence of healthcare professionals; and
To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal
representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other
community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as joint notice. Information will be shared as necessary to carry out

treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to
participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

Food and Drug Administration
Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability Correctional Institutions
Workers Compensation Agents
Organ and Tissue Donation Organizations
Military Command Authorities
Health Oversight Agencies
Funeral Directors and Coroners
National Security and Intelligence Agencies
Protective Services for the President and Others
A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Staff.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we do not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Practice Administrator.

We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask if we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this
notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link. To exercise any of your rights, please obtain the required forms from the Practice Administrator and submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for
treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for

filing a complaint. OTHER

USES OF HEALTH

INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only
with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your

authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Practice Administrator: Please dial the telephone number below and ask for the facility administrator.

Telephone Number (954) 228-3019

Email Address: contact@inmotionhlth.com

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Name of Patient/Authorized Representative (Print) Relationship to Patient

INMOTION HEALTH, PA

Telehealth Consent Form

For convenience of accessing care, INMOTION HEALTH, PA, offers remote Telehealth consultations between patients and clinicians via a secure video platform. Additionally, your healthcare provider may consult with other providers or specialists remotely about your care via video or phone. Please carefully review this form and indicate your acceptance below.

Potential benefits of Telehealth include:

- Convenience in accessing your providers from your home or another location.
- Protection against the transmission of communicable illnesses between yourself and other patients and clinic staff.
- Improvements to the quality of care when your clinician can consult with other providers as needed.

Inherent in the use of Telehealth are technological risks of disruption to the call or video connection and other technical difficulties. You or the provider may discontinue the Telehealth consultation if either of you determine that technical difficulties are too disruptive to continue.

We take strong precautions to safeguard the privacy of your protected health information (PHI), including using only HIPAA-compliant platforms for Telehealth. Nevertheless, there is an unavoidable risk of unauthorized access when sending/ receiving PHI electronically (for example, via a video feed). You are solely responsible for ensuring privacy and confidentiality on your side - by conducting the visit in a private space where others cannot overhear and cannot see private information on the screen. We do not record (voice or video) Telehealth consultations, but the health care provider will retain a medical record of care in their secure electronic health records system.

Some visits - specifically, those that require the clinician to be physically present with you - are not suitable for Telehealth. Your provider may ask that you schedule an in-person visit for any issues that require in-person evaluation or treatment. Telehealth is not a substitute for emergency care. If you need urgent care, call 911 or go to the nearest urgent care facility.

You are responsible for the cost of your Telehealth consultation. If you are seeking insurance payment or reimbursement for the visit, note that insurance companies may require that you participate in the Telehealth consultation from a hospital, a mental health facility, a physician's office, an adult care facility, or your home.

I understand the following recommendations given to me about privacy:

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use Telehealth technology that is designed to protect your privacy.
- There is a very small chance that someone could use technology to hear or see your Telehealth visit.
- If you use the Internet for Telehealth, use a network that is private and secure.

I have read and understood the following practice policies:

- The patient must be located or resides in Florida at the time of the appointment.
- No recordings of audio or video are allowed.
- Choose a quiet room. Other people will not be allowed to see or listen to the visit unless it is a legal tutor, or you need technical help.
- Please do not drive during the appointment.
- Make sure you are appropriately dressed as if you were visiting the office.
- Make sure to turn off all other electronic devices or social media.
- Make sure to be connected to the patient portal and ready for your visit at least 10 minutes prior to the scheduled time.
- Controlled substances will not be prescribed.
- If you have not submitted your payment or all patient forms have not been completed at least 15 minutes prior to the appointment, your appointment could be cancelled or rescheduled.
- If we encounter technical difficulties the appointment may need to be rescheduled.

Patient Consent To The Use of Telehealth

- I have read this form - or had it read and explained to me - in full. I fully understand its contents, including the risks, benefits, and alternatives.
- I have been given opportunity to ask questions and any questions have been answered to my satisfaction.

I hereby give my informed consent to the use of Telehealth in the course of my diagnosis and treatment.

By signing below, I acknowledge and agree:

I have carefully read the information on this Consent Form and understand I may be giving up some important legal rights by signing.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

IF PARTICIPANT IF UNDER THE AGE OF 18:

Signature of Parent or Guardian:_____

Parent or Guardian/Print Name:_____ Date:_____

BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT. **It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.** The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT. The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by the undersigned provider of medical services or the provider's partners, agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL. BOTH PARTIES TO THIS AGREEMENT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties' consent to the

participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES. The parties agree and recognize that the substantive provisions of the State of Florida laws, rules and regulations governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects, except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida laws, rules and regulations. (which remain available if elected by the parties), the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within thirty (30) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy under this Agreement, the parties to the dispute or controversy shall each appoint an independent arbitrator who is a member of the American Health Lawyers Association and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator, who shall also be a member of the American Health Lawyers Association and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

6. ARBITRATION EXPENSES. Each party shall bear the cost of her/its own attorneys' fees, the costs of presenting her/its case, and her/its arbitrator. Other costs of the arbitration (e.g. of securing a location for the arbitration, neutral arbitrator, court reporter, etc.) shall shared by the parties.

7. APPLICABLE LAW. This Agreement shall be governed by and construed and enforced under the laws of the State of Florida. Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration in the State of Florida, before a single arbitrator, in accordance with the Rules of Procedure for Arbitration of the American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service, and judgment upon the award rendered by the arbitrator(s) shall be entered in any court having jurisdiction thereof. For the purpose of entering such Arbitration Award as a State Court Judgment, the parties hereto consent to the jurisdiction and venue of an appropriate court located in the State of Florida. A party may initiate such arbitration by making written demand for arbitration on the other party. The demand shall contain a statement setting forth the nature of the dispute, the amount of damages involved, if any, and the remedies sought. The parties agree that only claims asserted pursuant to this agreement will be arbitrated in a proceeding initiated under this section and such claims shall not be consolidated or coordinated in any arbitration action with the claim of any other individual or entity. No claim may be arbitrated on a coordinated, class, mass, collective or consolidated basis. No claim may be brought as a class action or as a private attorney general. In no event will this

arbitration clause be interpreted to allow a class action in arbitration. The actual cost of the arbitration, including the fees of the arbitrator(s) shall be borne equally by the parties. In the event that Arbitration (or litigation relating to domestication of Arbitration Award) results from or arises out of this Agreement or the performance thereof, the parties agree to reimburse the prevailing party's reasonable attorney's fees, court costs, and all other expenses, whether or not taxable by the court as costs, in addition to any other relief to which the prevailing party may be entitled. In such event, no action shall be entertained by said court or any court of competent jurisdiction if filed more than one (1) year subsequent to the date the cause(s) of action actually accrued regardless of whether damages were otherwise as of said time calculable.

8. EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION. In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. SEVERABILITY. If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

10. ACKNOWLEDGEMENTS BY PATIENT. The patient, by signing this Agreement, also acknowledges that he or she has been informed that:

    a. NO DURESS. The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

    b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign this Agreement is solely a matter for the patient's determination without any influence by the medical provider;

    c. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or

defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision. However, any party may, within 15 days from a decision of an arbitration panel, file a written request for reconsideration. Any such request for reconsideration shall be based upon (i) a claim that the panel failed to properly apply the law or applicable rules of evidence or (ii) that the procedures specified in this Agreement were not followed. A claim that the panel was incorrect as to the facts, or gave undue weight to certain evidence will not be a basis for a request for reconsideration; and

d. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be executed and delivered as of the date first above written.

Carly Oliveri, PA-C, President of **INMOTION HEALTH, P.A.**, as an agent of its employees, partners, agents, and independent contractors.

Patient:

Print name: Date

Patient Signature

Parent or Guardian

Print name

Date

Parent or Guardian Signature

InMotion Health, P.A.

Home Visit Safety Acknowledgment

For the safety of both patient and provider, I acknowledge and agree to the following:

- My home will be free of any immediate hazards (e.g., unsecured pets, weapons, aggressive behavior, biohazards).
- I will secure all animals during the visit.
- I will notify the provider in advance if anyone in the home is currently sick with a contagious illness.
- If requested, I will wear a face covering during the visit (especially if experiencing respiratory symptoms).
- I will ensure a clean, well-lit space is available for the visit with a flat surface for supplies if needed.

I understand that **InMotion Health, P.A. reserves the right to cancel or reschedule** a home visit at any time if the environment is deemed unsafe or non-compliant with the above conditions.

Patient (or Guardian) Name: _____
Patient Signature: _____
Date: _____

Parent/Guardian Signature (if applicable): _____
Relationship: _____
Date: _____

INMOTION HEALTH, PA

WEBSITE PRIVACY POLICY

Last Updated: August 7, 2025

OVERVIEW:

We respect your privacy. This Privacy Policy describes the privacy practices of INMOTION HEALTH, PA, a Florida professional association (collectively, "Company" or "INMOTION HEALTH " or "we" or "us" or "our"), the Personal Data we collect about you, how we collect it, how we use it and with whom we share it. This Privacy Policy also describes the choices you can make about how we collect and use your Personal Data. This Policy does not apply to the practices of companies that we do not own or control, or to people whom we do not employ or manage.

By using the Service, whether on our web application or on our mobile device, you agree to the collection and use of information in accordance with this Privacy Policy. This Privacy Policy is subject to and incorporated within the Service's End User Agreement ("EULA"), including its provisions on liability and dispute resolution. Capitalized terms not otherwise defined in this Privacy Policy shall have the meanings ascribed to them in the EULA.

DEFINITIONS:

- Cookies. Cookies are small pieces of data stored on your device (computer or mobile device).

- Data Controller. Data Controller means the natural or legal person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any Personal Data are, or are to be, processed. For the purpose of this Privacy Policy, we are a Data Controller of your Personal Data.

- Data Processors (or Service Providers). Data Processor (or Service Provider) means any natural or legal person who processes the data on behalf of the Data Controller. We may use the service of various Service Providers in order to process your data more effectively.

- Data Subject (or User). Data Subject is any living individual who is using our Service and is the subject of Personal Data. For the purpose of this Privacy Policy, you are a Data Subject.

- Personal Data. Personal Data means information about a living individual who can be identified from such information (or from those and other information either in our possession or likely to come into our possession).

- Usage Data. Usage Data is data collected automatically by the use of the Service infrastructure itself (for example, dates and times of Service visits or usage, the duration of a page visit or the use of an app, IP addresses, browser characteristics, device characteristics, operating system, language preferences, referring URLs and information on actions taken on our Service).

HOW WE COLLECT YOUR PERSONAL DATA:

We collect information in different ways from individuals who access the Service. We collect information from you in the following ways:

- When you sign-up to use the Service.

- When you provide information to create your account and build your profile or to associate with one or more agencies.

- When you enter your calendar and schedule information through the Service.

- When you access the Service by using our mobile app.

- Through third party tools used to collect User behavior, such as through Cookies. We may also receive reports based on the use of these technologies from our Service Providers on an individual as well as aggregated basis.

- Through Local Storage Objects (LSOs) such as HTML5 or Flash to store content information and preferences.

WHAT TYPES OF PERSONAL DATA WE COLLECT:

We collect different information from you depending on how you engage with us.

- We collect your name, email, and phone number when you provide it to us by signing up to use the Service.

- We collect your professional description and office location when you set up your account and profile.

- We collect you association with your agencies and groups when you associate your profile to them through the Service.

- We collect your calendar information when you using the Service, including practitioner availability, consultation requests and scheduled patient visits.

- We collect patient biographical information that you enter to schedule patient requests and patient visits, but we our collection of any PHI as defined under HIPAA is as a Data Processor for the applicable healthcare covered entity. Our obligations with respect to PHI will be set forth under a separate Business Associate Agreement entered into with the applicable healthcare covered entity.

- We collect your location when using our mobile app.

- We automatically collect Usage Data through your use of the Service.

HOW WE PROCESS AND USE YOUR PERSONAL DATA:

We may process and use your Personal Data primarily to perform a contract with you, and to otherwise deliver the Service or a service that you request, including:

- To create your account and profile.

- To associate you with the agencies and groups that you select.

- To provide you with consultation requests.

- To fulfill your request to schedule patient or practitioner consultations, as applicable.

- To assist us in operating and improving the Service.

We may also process your Personal Data because it is necessary for our or a third party's legitimate interests and it’s not overridden by your rights. In this respect, we may use your Personal Data to:

- To contact you via email, postal mail, or telephone to learn more about your preferences, to conduct market research and learn more about how we can improve our offerings.

- To track Service performance, to make your visit better, and for aggregate Service analytics.

- To analyze trends, measure page views and performance, administer the Service, track Users’ movements around the Service and to gather demographic information about our User base as a whole.

- We use Cookies and LSOs to remember Users' preferences (e.g. search filters), for authentication, for source tracking, for analytics, or for product recommendations.

We may also process your Personal Data for our compliance with our legal obligations. In this respect, we may use your Personal Data for the following:

- When necessary to conform to legal requirements or to respond to a subpoena, search warrant or other legal process received by us, whether or not a response is required by applicable law.

- When necessary to enforce or apply our EULA and other related agreements.

- To protect our rights or the property or safety of our employees, Users or members of the general public.

Notwithstanding, **INMOTION HEALTH** is not legally responsible and cannot guarantee that any of its vendors, marketing partners, contractors, and/or any legal entity doing business with INMOTION HEALTH (not considered a partner and/or equity member of INMOTION HEALTH) performs any data collections that may result in monetary gains to said legal entity.

WITH WHOM WILL WE SHARE YOUR PERSONAL DATA:

We generally do not share your Personal Data with third parties. However, we may share your Personal Data:

- If we have received your permission beforehand.

- With our employees, if necessary for the development, improvement, and provision of our Service. Our employees must have a business reason to obtain access to your Personal Data.

- With Service Providers, such as processors when they meet the requirements of this Privacy Policy, and when necessary for the purposes of providing the Service, (e.g., statistical analyses and data processing).

- Under certain circumstances, if required to do so by law or in response to valid requests by public authorities (e.g. a court or a government agency).

- If in good faith, we believe that such action is necessary to comply with a legal obligation or to protect and defend our rights or property.

- To a successor entity upon a merger, consolidation or other corporate reorganization in which we participate or to a purchaser of all or substantially all of our assets to which this Service relates.

YOUR DATA PROTECTION RIGHTS AND CHOICES:

We aim to take reasonable steps to allow you to correct, amend, delete, or limit the use of your Personal Data. If you wish to be informed what Personal Data we hold about you and if you want it to be removed from our systems, please contact us using the details set out below. You have the right to:

- Access or update the information we have on you. Find out if we use your Personal Data, access your Personal Data and have it corrected or amended if it is inaccurate or incomplete.

- Withdraw consent. Withdraw any express consent that you have provided to the processing of your Personal Data at any time without penalty.

- Object. You have the right to object to our processing of your Personal Data.

- Data portability. Obtain a transferable copy of some of your Personal Data which can be transferred to another provider when the Personal Data was processed based on your consent.

- Rectification. If you believe your Personal Data is inaccurate, no longer necessary for our business purposes, or if you object to our processing of your Personal Data, you also have the right to request that we restrict the processing of your data pending our investigation and/or verification of your claim.

- Deletion or restriction. Request your Personal Data be deleted or restricted under certain circumstances. For example, if INMOTION HEALTH is using your Personal Data on the basis of your consent and has no other legal basis to use such, you may request your Personal Data be deleted when you withdraw your consent.

If you wish to exercise any of these rights, or raise a complaint on how we have handled your Personal Data, please contact us at (954) 228-3019 or contact@inmotionhlth.com or via the details below.

You additionally have choices regarding the collection, use, and sharing of your Personal Data.

- You have a right at any time to stop us from contacting you for promotional marketing purposes. If now or in the future you receive promotional or electronic newsletter

communications from us, you may indicate a preference to stop receiving such communications from us, and you will have the opportunity to "opt-out" by clicking the "Unsubscribe" hyperlink at the bottom of all such communications. Notwithstanding your indicated email marketing preferences, we may send you administrative emails regarding the Service, including, for example, order confirmations or updates to our Privacy Policy or the EULA.

- You may be able to configure your browser to accept or reject all or some Cookies, or notify you when a Cookie is set — all browsers are different, so check the "Help" menu of your particular browser to learn how to change your Cookie preferences. Please note that if you have set your browser to refuse Cookies, you will not be able to be authenticated and thereby you will not be able to use the Service - you will only be able to browse public portions of our website. Users can control the use of Cookies at the individual browser level. Various browsers may offer their own management tools for removing HTML5 LSOs.

RETENTION OF DATA:

We will retain your Personal Data only for as long as is necessary for the purposes set out in this Privacy Policy. We will retain and use your Personal Data to the extent necessary to perform a contract with you, comply with our legal obligations (for example, if we are required to retain your data to comply with applicable laws), resolve disputes, and enforce our legal agreements and policies.

We will also retain Usage Data for internal analysis purposes. Usage Data is generally retained for a shorter period of time, except when this data is used to strengthen the security or to improve the functionality of our Service, or we are legally obligated to retain this data for longer time periods.

SECURITY OF DATA:

The security of your data is important to us, but remember that no method of transmission over the Internet, or method of electronic storage is 100% secure. We take precautions to insure that our visitors' Personal Data is secured and we strive to use commercially acceptable means to protect your Personal Data, but we cannot guarantee its absolute security.

We use a variety of industry-standard technical, contractual, administrative and physical security measures and procedures to help protect your Personal Data from unauthorized access, use, alteration or disclosure. Unless otherwise provided, we restrict access to Personal Data to those employees who need access to perform their job functions. Please note that despite our best

efforts, no one can guarantee the security of Personal Data. Unauthorized entry or use, hardware or software failure, and other factors may compromise the security of Personal Data at any time.

SERVICE PROVIDERS:

We may employ Service Providers, to process Service-related data on our behalf, to perform Service-related service or to assist us in analyzing how our Service is used. Each of these Service Providers is contractually obligated to provide services to us in a manner consistent with this Privacy Policy.

These third parties have access to your Personal Data only to perform these tasks on our behalf and are obligated not to disclose or use it for any other purpose and must comply with the requirements for third party processors set forth in this Privacy Policy.

THIRD PARTY EMBEDS:

Some of the content that you see displayed on INMOTION HEALTH website and App may not necessarily be hosted by INMOTION HEALTH . These “embeds” are hosted by a third-party and embedded in a INMOTION HEALTH page, so that it appears to be part of that page. These files send data to the hosted site just as if you were visiting that site directly.

INMOTION HEALTH does not control what data third parties collect in cases like this, or what they ultimately do with it. As such, any such third-party embeds on INMOTION HEALTH are not covered by this Privacy Policy. They are covered by the privacy policy of the third-party service.

Some embeds may ask you for personal information, such as submitting your email address, through a form linked to from INMOTION HEALTH . We do our best to keep bad actors off INMOTION HEALTH . However, if you choose to submit your information to a third party this way, we do not know what they may do with it. As explained above, their actions are not covered by this Privacy Policy.

OUR LIABILITY FOR TRANSFERS OF YOUR PERSONAL DATA:

We require third-party controllers to whom we disclose your Personal Data to contractually agree to (i) only process such Personal Data for the limited and specified purposes consistent with the consent you provide; and (ii) provide the same level of protection to your Personal Data as required under this Privacy Policy; and (iii) notify us if the third-party controller makes a determination that it can no longer meet the foregoing obligations.

In addition, when we transfer your Personal Data to a third party processor acting as our agent, we will: (i) transfer such Personal Data only for the limited and specified purposes consistent with the request or consent you provide; (ii) contractually require the processor to provide at

least the same level of privacy protection as is required by this Privacy Policy; (iii) require the processor to notify us if it makes a determination that it can no longer meet its obligation to provide the same level of protection as is required by the this Privacy Policy. Should we receive any such notice, we will take reasonable and appropriate steps to stop and remediate unauthorized processing.

We shall remain liable should our processors process Personal Data in a manner inconsistent with this Privacy Policy, unless we can prove we are not responsible for the event giving rise to the damage. We acknowledge our liability for such data transfers to third parties in violation of this Privacy Policy.

EMAILS FROM INMOTION HEALTH :

Sometimes we may send you emails about your account, service changes or new policies. You cannot opt out of this type of "transactional" email (unless you delete your account). However, you can opt out of non-administrative emails such as digests, newsletters, and activity notifications through your account's settings page.

When you interact with an email sent from INMOTION HEALTH (such as opening an email or clicking on a particular link in an email), we may receive information about that interaction.

We will not email you to ask for your password or other account information. If you receive such an email, please disregard it immediately.

CHILDREN'S PRIVACY AND INTERNATIONAL CONSIDERATIONS:

Our Service does not address anyone under the age of 18 ("Children").

We do not knowingly collect personally identifiable information from anyone under the age of 18. If you are a parent or guardian and you are aware that your child has provided us with Personal Data, please contact us. If we become aware that we have collected Personal Data from children without verification of parental consent, we take steps to remove that information from our servers.

INQUIRIES AND CONTACT TERM:

BY USING OUR SITE, APPLICATION, AND SERVICES OR ACCESSING, YOU ACKNOWLEDGE AND ACCEPT THAT SUBMITTING YOUR TELEPHONE NUMBER TO US VIA THE SITES AND SERVICES CONSTITUTES AN INQUIRY TO US, AND THAT WE OR OUR AFFILIATES MAY CONTACT YOU AT THE NUMBER SUBMITTED EVEN IF SUCH NUMBER APPEARS ON ANY STATE OR FEDERAL DO NOT CALL LISTS (TAKING INTO ACCOUNT INQUIRY EXCEPTION TIME FRAMES AS APPROPRIATE).

You authorize us to contact you by telephone at the number you have provided. Telephone calls may include prerecorded or artificial voice messages and calls using an automatic telephone dialing system. Your consent is not a condition of your purchase.

You agree that any calls to or from us may be monitored or recorded for training or quality assurance purposes.

INDEMNIFICATION:

You agree to indemnify and hold us and our representatives harmless from and against any third-party claim, cause of action, demand or damages related to or arising out of: (a) content that you post or transmit (including but not limited to content that a third-party deems defamatory or otherwise harmful or offensive); (b) activity that occurs through or by use of your account (including, without limitation, all content posted or transmitted and your interactions with others); (c) your use of or reliance on any user content; and (d) your violation of these. This indemnification obligation includes payment of any attorneys' fees and costs incurred by us or our representatives. We reserve the right, at our own expense, to assume the exclusive defense and control of any matter otherwise subject to indemnification by you, and you agree to cooperate with our defense of these claims.

DISCLAIMERS:

YOUR ACCESS TO, USE OF AND RELIANCE ON OUR SITE AND SERVICES AND CONTENT ACCESSED THROUGH OUR SITE AND SERVICES IS ENTIRELY AT YOUR OWN RISK. OUR SITE AND SERVICES (INCLUDING, WITHOUT LIMITATION, THE WEBSITES, PROGRAMS, SERVICES, FORUMS AND CONTENT ACCESSED THROUGH THE WEBSITES, PROGRAMS, SERVICES AND FORUMS) IS PROVIDED ON AN "AS IS" OR "AS AVAILABLE" BASIS WITHOUT ANY WARRANTIES OF ANY KIND.

ALL EXPRESS AND IMPLIED WARRANTIES (INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND NON-INFRINGEMENT OF PROPRIETARY RIGHTS) ARE EXPRESSLY DISCLAIMED.

WITHOUT LIMITING THE FOREGOING, WE ALSO DISCLAIM ALL WARRANTIES FOR OR WITH RESPECT TO: (A) THE SECURITY, RELIABILITY, TIMELINESS, ACCURACY AND PERFORMANCE OF OUR SITE AND SERVICES AND CONTENT ACCESSED THROUGH OUR SITE AND SERVICES; (B) COMPUTER WORMS, VIRUSES, SPYWARE, ADWARE AND ANY OTHER MALWARE, MALICIOUS CODE OR HARMFUL CONTENT OR COMPONENTS ACCESSED, RECEIVED OR DISSEMINATED THROUGH, RELATED TO OR AS A RESULT OF OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES; AND/OR (C) ANY TRANSACTIONS OR

POTENTIAL TRANSACTIONS, GOODS OR SERVICES PROMISED OR EXCHANGED, INFORMATION OR ADVICE OFFERED OR EXCHANGED, OR OTHER CONTENT, INTERACTIONS, REPRESENTATIONS OR COMMUNICATIONS THROUGH, RELATED TO OR AS A RESULT OF USE OF OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES (INCLUDING, WITHOUT LIMITATION, ACCESSED THROUGH ANY LINKS ON OUR SITE AND SERVICES OR IN CONTENT).

THESE DISCLAIMERS WILL APPLY TO THE FULLEST EXTENT PERMITTED BY LAW. Some jurisdictions do not allow disclaimers of implied warranties. In such jurisdictions, some of the foregoing disclaimers as to implied warranties may not apply.

LIMITATIONS OF LIABILITY:

WE AND OUR REPRESENTATIVES WILL UNDER NO CIRCUMSTANCES BE LIABLE FOR ANY ACCESS TO, USE OF OR RELIANCE ON OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES BY YOU OR ANYONE ELSE, OR FOR ANY TRANSACTIONS, COMMUNICATIONS, INTERACTIONS, DISPUTES OR RELATIONS BETWEEN YOU AND ANY OTHER PERSON OR ORGANIZATION ARISING OUT OF OR RELATED TO OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES, INCLUDING BUT NOT LIMITED TO LIABILITY FOR INJUNCTIVE RELIEF AS WELL AS FOR ANY HARM, INJURY, LOSS OR DAMAGES OF ANY KIND INCURRED BY YOU OR ANYONE ELSE (INCLUDING, WITHOUT LIMITATION, DIRECT, INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL, STATUTORY, EXEMPLARY OR PUNITIVE DAMAGES, EVEN IF WE OR OUR REPRESENTATIVE HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES). THIS LIMITATION OF LIABILITY APPLIES REGARDLESS OF, BUT IS NOT RESTRICTED TO, WHETHER THE ALLEGED LIABILITY, HARM, INJURY, LOSS OR DAMAGES AROSE FROM AUTHORIZED OR UNAUTHORIZED ACCESS TO OR USE OF OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES; ANY INABILITY TO ACCESS OR USE OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES, OR ANY REMOVAL, DELETION, LIMITATION, MODIFICATION, INTERRUPTION, SUSPENSION, DISCONTINUANCE OR TERMINATION OF OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES.

THESE LIMITATIONS WILL ALSO APPLY WITH RESPECT TO DAMAGES RESULTING FROM ANY TRANSACTIONS OR POTENTIAL TRANSACTIONS, GOODS OR SERVICES PROMISED OR EXCHANGED, INFORMATION OR ADVICE OFFERED OR EXCHANGED, OR OTHER CONTENT, INTERACTIONS, REPRESENTATIONS, COMMUNICATIONS OR RELATIONS THROUGH, RELATED TO OR AS A RESULT OF OUR SITE AND SERVICES OR CONTENT ACCESSED THROUGH OUR SITE AND SERVICES (INCLUDING, WITHOUT LIMITATION, ANY LINKS ON OUR SITE AND

SERVICES AND LINKS IN CONTENT ACCESSED THROUGH OUR SITE AND SERVICES).

You hereby release us and each of our representatives, and their respective subsidiaries, affiliates, successors, predecessors, assigns, heirs, service providers and suppliers, from all claims, demands and damages of every kind and nature, known and unknown, direct and indirect, suspected and unsuspected, disclosed and undisclosed, arising out of or in any way related to our site and Services or content accessed through our site and Services, or any interactions with others arising out of or related to our site and Services or content accessed through our site and Services.

THESE LIMITATIONS WILL APPLY TO THE FULLEST EXTENT PERMITTED BY LAW.

CHANGES TO THIS PRIVACY POLICY:

From time-to-time we may modify, change, update, add to, remove portions of or otherwise alter this Privacy Policy. We will notify you of any changes by posting the new Privacy Policy on this page.

We will let you know via email and/or a prominent notice on our Service, prior to the change becoming effective and update the "effective date" at the top of this Privacy Policy.
You are advised to review this Privacy Policy periodically for any changes. Changes to this Privacy Policy are effective when they are posted on this page. If you object to any such changes, you must immediately cease using the Service.

CONTACT, QUESTIONS, OR FEEDBACK:

When we receive formal written complaints, it is our policy to contact the person regarding his or her concerns. We will cooperate with the appropriate regulatory authorities, including local data protection authorities, to resolve any complaints regarding the transfer of Personal Data that cannot be resolved between us and an individual.

CONTACT US:

If you have any questions about our Privacy Policy, you can always contact us in any of three ways:

1. Send us an e-mail: contact@inmotionhlth.com
2. Call us at (954) 228-3019

3. Write to us at:

INMOTION HEALTH, PA

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