Terms & Conditions

Terms and conditions of NU Life Wellness Clinic

I understand that participating in intravenous ("**IV**") hydration, vitamin/supplement administration, pharmaceutical administration, programs, and services made available by Nu Life Wellness Clinic carries health risks. Risks include, but are not limited to, injury, bleeding, infection, inflammation/swelling, bruising, or scarring from IV infiltration, extraction and extravasation, misplacement of IV lines in the body, air embolism, fluid overload, medication adverse interactions, nerve injuries, lightheadedness, or fainting. To the extent that I fail to disclose any of my health conditions, medications, or drug use in advance, I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my choosing to participate in such regiment, programs, and services rests entirely with me. I expressly represent to NU Life Wellness Clinic that I have never been, diagnosed with nor treated for any diseases, illnesses or conditions which may result in increased risk when I participate in regimens, programs or services made available by NU Life Wellness Clinic. In addition, I am not choosing to participate with any expectation that NU Life Wellness Clinic will screen for, diagnose, monitor, or otherwise provide any care or treatment for such conditions. I acknowledge and understand that NU Life Wellness Clinic is relying upon the foregoing representations that I am providing to NU Life Wellness Clinic in choosing to accept me for participation in its program(s) or service(s). I acknowledge that NU Life Wellness Clinic made no warranties or guarantees as to the results or general success of the IV, vitamin/supplement administration, pharmaceutical administration, programs, or any other services made available by NU Life Wellness Clinic and all expressions, oral or in writing, made by NU Life Wellness Clinic relative thereto, are opinions that should not be relied upon. I acknowledge that ancillary damage may occur to me or to my property because of participating in IV hydration, vitamin/supplement administration, pharmaceutical administration, or any program/service made available by NU Life Wellness Clinic. I hereby hold NU Life Wellness Clinic entirely harmless and will fully indemnify NU Life Wellness Clinic against all such damages.

I acknowledge that the services provided have not been evaluated by the US Food and Drug Administration. I acknowledge that these products are not intended to diagnose, treat, or cure any disease. I expressly represent and guarantee to NU Life Wellness Clinic that I am not a user of illegal drugs or controlled substances, and I am not under the influence of or recovering from any drugs or controlled substances at the time of any service provided to me by NU Life Wellness Clinic. In the event of an emergency, I will call 911 or proceed to the nearest emergency room.

Acknowledgement: I confirm that I have read this form and fully understand its contents. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the sessions and programs offered by NU Life Wellness Clinic. I understand the nature of the sessions and programs and that participating in them carries risks. I have been given an opportunity to ask questions, and all my questions have been answered fully and to my satisfaction. I assume all risks associated with my participation.

Patient Authorization for Use and Disclosure of Protected Health Information: By signing this form, I authorize NU Life Wellness Clinic to use or disclose certain personal information, if necessary. NU Life Wellness Clinic may disclose (not limited to) the following: date(s) of service(s), type of service(s), any data source, age, gender, and vital signs. The information will be used or disclosed for (I) research data to reflect growth, and (ii) any type of service requested by NU Life Wellness Clinic' current or prospective clients. This authorization expires one year from the date of service. NU Life Wellness Clinic will not receive payment or other remuneration from a third-party in exchange for personal information. I understand I am not obligated to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be subject to the HIPAA Privacy Rule when adhering to certain protocol. I hereby give NU Life Wellness Clinic, and any employees or agents of NU Life Wellness Clinic, the right and permission to use or publish any photographs taken of me for art or promotional purposes including, but not limited to, advertising, publicity, or commercial/display of use. I also authorize my pictures to be posted on social media (e.g., Facebook, Twitter, TikTok), including NU Life Wellness Clinic' website. I hereby release and discharge NU Life Wellness Clinic and any related employee/agent from any legal or equitable claim originating from, but not limited to, (a) blurring of any image(s), (ii) alteration, (iii) distortion or use in composite form, (iv) libel, (v) invasion of privacy, or (vi) any claim based on the production or publishing of any material resulting from a service provided by NU Life Wellness Clinic. I consent to NU Life Wellness Clinic using my name, image or quote for any promotion and I understand all proprietary rights (e.g., property rights) are owned by NU Life Wellness Clinic. I consent to using my name, image, or quotes as determined by NU Life Wellness Clinic in, but not limited to, media content (e.g., website or Facebook Page for NU Life Wellness Clinic).

Credit/Debit Card Authorization: By signing this form, I authorize NU Life Wellness Clinic to debit my credit card provided for any product/service rendered and understand the authorization to be valid.

I consent to the above terms:

Print: _____ Sign: _____ Date: _____

HIPAA for NU Life Wellness Clinic

This Notice of Privacy Practices describes how we may use and disclose your protected health information to conduct treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, which may identify you and that relates to your past, present or future practitioner or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your practitioner, our office staff, and others outside of our office who engage in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your practitioner’s practice. The following are examples of the types of uses and disclosures of your protected health information that your practitioner’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. We will also disclose protected health information to other practitioners who may be treating you. For example, your protected health information may be provided to a practitioner to whom you have been referred to ensure that the practitioner has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another provider who, at the request of your practitioner, becomes involved in your care by aiding with your health care diagnosis or treatment to your practitioner.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your protected health information to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

- Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
- Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- Additional situations include but are not limited to: Abuse and neglect, Criminal Activity, Workers' Compensation, Communicable disease, Research approved by IRB, Public health, and Legal proceeding.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that relates to that person's involvement in your health care. If

you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your practitioner and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your practitioner is not required to agree to a restriction that you may request. If your practitioner does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your practitioner. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to us. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

I read, acknowledge, and agree to the above.

Print: _____ Sign: _____ Date: _____

Agreement for Telehealth

NU Life Wellness Clinic (the "Practice") is honored to provide you with personalized support and care for the duration of your participation in our telehealth program (the "Program").

1. **Informed Consent for Telehealth Services.** You agree to receive telehealth services for the duration of your participation in the Program. Telehealth involves the use of audio, video, or other electronic communications to interact with you, consult with your service provider, and/or review your medical information for the purpose of diagnosis, therapy, follow-up, coaching and/or education; telehealth may be provided as synchronous (in real time) or asynchronous (not in real time, such as by sending a chat or a photo and later receiving a response). During your telehealth consultation with the Practice, details of your medical history and personal health information may be collected and such information may be disclosed and/or discussed with other health professionals involved in your care and treatment using interactive video, audio, and telecommunications technology. The benefits of telehealth include having access to specialists and additional medical information and education without having to travel outside of your home or local health care community. A potential risk of telehealth is that because of your specific medical condition or due to technical problems, a face-to-face consultation may still be necessary after the telehealth appointment. You agree that the Practice shall determine whether the condition being diagnosed and/or treated is appropriate for a telehealth encounter. Additionally, while the Practice shall comply with all administrative, physical, and technical safeguards set forth in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, in rare circumstances, security protocols could fail, causing a breach of patient privacy. Practice shall hold you harmless for any information lost due to technical failures. The alternative to receiving telehealth services is to not receive them. You understand the risks, benefits, and alternatives of receiving telehealth services. You may ask your provider any questions you may have regarding telehealth services. You may be asked to sign additional consents or provide additional information before receiving telehealth services if you reside in a state where additional documentation or additional information is required prior to receiving telehealth services.

   Our services should not be used for emergency care or services. **If you are experiencing a medical emergency, please call 911 immediately, or go to the nearest emergency room.**

2. **Confidentiality and Compliance.** We will take appropriate precautions to keep your health information confidential and not disclose it without your consent. You are also protected under the provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any other applicable federal and state laws related to the protection of patient information and how we will use and disclose your protected health information.
3. **Consent to Call, Email, Text, and Application Messaging.** You expressly consent to allow our agents and us to communicate with you by telephone call, email, text message,

and/or other forms of unencrypted electronic messaging ("Electronic Messages") using any telephone numbers or email addresses that you provide us or that we obtain lawfully. You expressly agree to receive prerecorded or automated Electronic Messages from us.

You understand the risks associated with communicating through Electronic Messages, including, without limitation, that Electronic Messages can easily be misaddressed to or forwarded to unintended recipients, that Electronic Messages can be stored, that backup copies of Electronic Messages may exist even after the Electronic Messages are deleted, that Electronic Messages may not be secure and thus may be used or forwarded without your permission or knowledge, that Electronic Messages may be inspected by your telephone carrier, and that Electronic Messages may be used as evidence in court. You understand that we are not liable for any breaches of confidentiality caused by you or a third party. You understand that Electronic Messages may be filed in your medical record. You may opt out of automated Electronic Messages, including SMS and/or email, at any time by sending a request via email to info@nulifetoday.com. You acknowledge and agree to receive a final message confirming your choice to opt out. Unless you revoke your consent to communicate with us via Electronic Messages, your consent will last for the duration of your participation in the Program.

In exchange for the services provided by us and to the extent not prohibited by law, you release us from all claims, causes of action, lawsuits, damages, losses, liabilities, or other harms relating to any Electronic Messages you exchange with us. To the extend not prohibited by law, You release us from all claims, causes of action, or lawsuits based on any alleged violations of any laws, including the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, HIPAA, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws.

4. **Notice Regarding Your Financial Responsibility for Services.** Neither the Practice nor any of its Providers are enrolled with or a participating provider with any federal or state healthcare programs (i.e., Medicare, Medicaid) for the provision of any healthcare services or supplies and, as such, you acknowledge and agree that (1) you have sole financial responsibility for all Subscription services or products you purchase, and (2) neither you, nor the Practice may submit a claim for reimbursement to any federal or state healthcare program for the costs of the services and products provided to you.
5. **Indemnification.** You agree to defend, indemnify and hold the Practice, its officers, directors, managers, partners, employees, agents, and suppliers harmless from and against all third-party claims, demands, damages, liabilities, costs and expenses including reasonable attorneys' fees against or incurred by the Practice arising out of your: (1) breach of these terms; (2) violation by you of any and all applicable laws, regulations or rules; or (3) your use of the Program's materials or features in an unauthorized manner.
6. **Arbitration Agreement.** You agree that any dispute between you and the Practice shall be resolved by binding, individual arbitration conducted before one commercial arbitrator from the American Arbitration Association ("AAA"), and you knowingly waive your rights to a jury trial and to participate in a class action lawsuit or class-wide

arbitration. The arbitration will be governed by the AAA's commercial arbitration rules and payment of arbitration costs will be governed by the AAA's fee schedule.

7. **Disclaimer.**
    a. The Services are not intended for individuals under the age of eighteen (18), and individuals under the age of eighteen (18) are prohibited from participating in the Program.
    b. Your compliance with all the terms described herein, as well as all applicable laws and regulations, is a condition of your participation in the Program.
    c. Your interactions with the Practice and participation in the Program is not intended to take the place of your relationship with your regular health care practitioners.
    d. Practice does not guarantee any specific outcomes associated with your participation in the Program.
    e. You agree that Practice shall not be liable for any damages, losses, or liabilities arising from the use of or reliance on the Program.
8. **Acknowledgment.** You have read and understand the information provided above and understand and agree to the terms in this Agreement, including the services, payment methods, and cancellation policy.

By accessing or using the services, clicking "I agree," checking a related box to signify your acceptance, or using any other acceptance protocol presented through the platform, you acknowledge that you have read, understood, and agreed to be legally bound by and comply with these terms. If you do not or cannot agree to any part of these terms, you may not participate in the Program.