2018 Wellness Consent & Service Agreement

Envision Health Partners, LLC

I, ____ voluntarily request and consent to an individualized wellness plan which may include unskilled &/or skilled treatment by Envision Health Partners. Services are outlined below & may be modified with my verbal consent.

1. Service(s)

❑ Monthly Wellness Membership ❑ Personalized Service Plan ❑ Massage Therapy / Therapeutic Touch

❑ Other ____

Details of Service (completed at client request): ____

2. Fee for Service(s)____

3. Client acknowledges that services rendered by Envision Health Partners Wellness programs are not reimbursable by insurance and 100% of payment is the responsibility of the client or the client's representative.

4. Membership services will be invoiced on the last day of the month. Invoices shall be mailed to the responsible party below.

For one-time service requests, payment is expected at time of service unless arranged otherwise.

ATTN: ____

Address: ____

City / State / Zip Code ____

Email: ______________________________________ Phone: ________________________________

5. Client understands that Envision Health Partners has incurred expenses in hiring and maintaining its employees, through advertising, recruiting, testing, training and reference/background checks. Client agrees not to hire Envision Health Partners employees directly or interfere with their employment without prior written consent from Envision Health Partners.

6. Envision Health Partners will endeavor to provide qualified personnel with professional experience and training who holds the appropriate certification or licensure to meet the delivery of services. Client acknowledges services are available to all members on a non-discriminatory basis.

7. Service interruption due to unforeseen circumstances, such as emergency client hospitalization may occur unexpectedly. Service interruption due to unforeseen circumstances will not be charged a cancellation fee. For planned interruptions in service, an alternate class time may be available but is not required. Failure to provide 24 hour notice may result in a cancellation fee equivalent to ½ anticipated rate of service.

8. Client agrees to indemnify and hold Envision Health Partners harmless from any claim, injury, loss or cause of action asserted by any third party arising from or in any way related to the performance services by Envision Health Partners employees or such employee's conduct, other than due to direct gross negligence or willful misconduct by Envision Health Partners.

9. Client acknowledges any liability of Envision Health Partners under this agreement shall be limited to direct damages and Envision Health Partners or it's representatives are not liable for any unforeseeable damages incurred in connection with the performance of these services, including but not limited to indirect, special, incidental and/or consequential damages.

10. Envision Health Partners will use reasonable efforts to provide appropriate services as requested by client, however, client understands that Envision Health Partners makes no express or implied representations or warranties to client or any other person as to the services provided.

11. Envision Health Partners maintains insurance coverage standard in the industry. Client understands that Envision Health Partners does not provide insurance covering physical loss/damage to client's

equipment or material in the care, control or custody of Envision Health Partners employee, and that Envision Health Partners is not responsible for any damage/physical loss thereto. Envision Health Partners will provide instructions for safety and proper use of equipment based n best practice standards, safety protocols and manufacturer recommendations and guidelines.

12. Envision Health Partners strongly recommends participating in all levels of assessment, screenings & preventative services in order to provide the appropriate level of service for your personalized membership. It is our desire to deliver a comprehensive program, individualized by your active participation in screenings and health assessments.

14. Because information is valuable in making healthy decisions about your overall physical, mental, and emotional status, we recommend the results of your wellness screenings be shared with all members of your healthcare team. We are happy to communicate this information per your written request. Please confirm your consent in sharing this information.

❑ Please share my information with my healthcare team; i.e. I do not have restrictions.

❑ Please share my information with the following: ____

❑ Please do not share my information and keep all wellness records confidential.

15. I authorize Envision Health Partners to coordinate on my behalf, additional services that are available through partnerships as identified below:

❑ On-site Physician Services *(not provided by Envision Health Partners)*
❑ Health Screenings ❑ Private Duty

Please dedicated a representative on my behalf for coordination of wellness services:

____
____
Representative Name Relationship

Contact Information: ____

Wellness Liability / Waiver Statement

I, the undersigned hereby expressly and affirmatively state that I wish to participate in the Envision Wellness Programs, being aware of my own health and physical condition, and having knowledge that my participation in any exercise program may put me at risk for injury. I hereby assume all risks connected therewith and consent to participate in this program. I agree to disclose any physical limitations, disabilities, ailments or impairments which may affect my ability to safely participate, including any changes in my health or physical condition.

I have been given the opportunity to ask questions and any questions I have asked have been answered to my complete satisfaction.

Name: ____ DOB _____________________

Address: ____

Email: ____ Phone ___________________

____
____
Client/Client's Representative/Responsible Party Date

____ _______________________________

Envision Health Partners Representative Date