CONDITIONS OF SERVICE

Oncura Health • 541 W. Colorado St, Suite 309 Glendale, CA 91204 • 323.254.0046

In this document, **"Patient"** means the person receiving treatment. **"Patient Representative"** means any person acting on behalf of the Patient. "I," "you," "your," or "me" may include both the Patient and the Patient Representative; with respect to financial obligations, also the "Guarantor."

"Provider" means the practice and may include **Oncura Health** physicians and/or staff, including but not limited to Oncologists, Radiologists, Radiation Oncologists, PAs, NPs, Social Workers, Behavioral Health Practitioners, and any authorized agents, contractors, affiliates, successors, or assignees.

1. CONSENT TO TREATMENT

I consent to medical care and procedures recommended by my Provider, including emergency care, lab tests, x-rays, imaging, diagnostics, and other treatments. I allow residents and supervised trainees to participate in or observe my care. I consent to blood-borne disease testing (hepatitis, HIV, AIDS) if ordered by my Provider; side effects are usually minor. Test results will be kept confidential in my medical record.

2. CONSENT TO TREATMENT USING TELEHEALTH

I consent to receive health care services through telehealth, including audio, video, or other electronic communications for diagnosis, treatment, consultation, follow-up, care management, or patient education. Applicable confidentiality and privacy protections apply equally to telehealth interactions (Cal. Bus. & Prof. Code § 2290.5(f)).

California Telehealth Disclosure — Cal. Bus. & Prof. Code § 2290.5

- Telehealth involves potential limitations and risks: technical failures, interruptions, delays, limitations on physical examination, and the possibility that insufficient information may be transmitted for appropriate medical decision-making.
- Use of telehealth is voluntary; I may withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I may seek in-person care instead of telehealth, where available. My consent will be documented in my medical record.

Additional California Notice for Medi-Cal Beneficiaries (Cal. Welf. & Inst. Code § 14132.725)

I have the right to access covered services through an in-person visit or through telehealth. If I have difficulty accessing in-person services due to transportation, coverage may be available when other resources are reasonably exhausted. Interpretation/translation services are available, as applicable.

3. FINANCIAL AGREEMENT

I (the Patient or Guarantor) agree to pay any balance not covered by insurance, including coinsurance, deductibles, non-covered services, or amounts due to policy limits or exclusions. If I overpay, the extra may be applied to other balances before a refund. I can request a free, itemized billing statement. Patients will not be billed for amounts prohibited by state or federal law, including applicable surprise billing protections.

4. PROFESSIONAL SERVICES BY INDEPENDENT CONTRACTORS

Independent contractors and advanced practice professionals providing services at the practice are not agents or employees of the practice, to the extent permitted by applicable law. I may receive a separate bill for professional services (e.g., radiology, pathology) that is separate from the practice bill.

5. LEGAL RELATIONSHIP BETWEEN PRACTICE AND PHYSICIANS

Independent physicians and advanced practice professionals are responsible for their own actions. The practice shall not be liable for their acts or omissions to the extent permitted by applicable law.

6. ASSIGNMENT OF BENEFITS

I assign my insurance benefits to the Provider and authorize direct payment to the Provider. I agree to help the Provider collect payment from any responsible party, including forwarding any payment I receive directly. I also

authorize the Provider to pursue claims, appeals, or legal remedies for unpaid or underpaid benefits. This assignment is full and unconditional to the extent permitted by applicable law.

Medicare Patient Certification and Assignment of Benefit

I certify that information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) is correct. I request payment of authorized benefits to be made on my behalf to the practice or its physicians.

Outpatient Medicare Patients — Self-Administered Drugs

Medicare generally does not cover self-administered drugs. If you receive such drugs not covered under Part B, we may bill you. If enrolled in a Medicare Part D Drug Plan, those drugs may be covered under Part D benefits.

7. CONSENT TO PHOTOGRAPHS, VIDEO, DIGITAL, AND AUDIO RECORDINGS

The practice's patient care, quality improvement, and risk management activities may involve photographs, video, digital and/or audio recordings of me, including recordings of telephone or virtual communications. Audio recording of conversations will only occur with my knowledge and consent, as required by applicable law. These images and recordings may only be used and disclosed as permitted by applicable law.

☐ I consent to photography ☐ I consent to audio/video recordings

Security Monitoring Notice: For safety and security purposes, video surveillance may be in use in common areas of the facility (entrances, waiting areas, hallways). Audio recording is not used for security monitoring.

8. CONSENT TO USE OF AI-ASSISTED DOCUMENTATION TOOLS

I understand that my provider may use secure, HIPAA-compliant technology, including artificial intelligence (AI) or digital scribe tools, to assist in documenting my care. These tools may process audio of my conversation with my provider to generate clinical documentation for my medical record. I understand that the AI tool is used only to assist with documentation and does not replace the clinical judgment of my provider, and that my provider reviews and finalizes all documentation entered into my medical record. I also understand that my information will be protected and handled in accordance with applicable privacy and security laws, and that audio and/or transcripts may be temporarily processed to support documentation and are maintained, stored, or deleted in accordance with the practice's policies and applicable law. I understand that I may decline or withdraw consent to the use of AI-assisted documentation at any time without affecting my access to care or treatment.

Practice Implementation Note (Remove Before Deployment):
Verify AI vendor's HIPAA-compliant BAA, CMIA compliance (Cal. Civil Code §§ 56 et seq.), and internal policies governing transcript retention and deletion before activating the checkboxes below.

☐ I consent to AI-assisted documentation tools ☐ I decline AI-assisted documentation tools

9. CONSENT TO TELEPHONE CALLS, EMAIL, OR TEXT MESSAGE

I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers that are forwarded or transferred from the information provided) for receiving information relating to my healthcare services and financial obligations, including healthcare-related information and financial communications. I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or obtained, or any number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. Methods of contact may include pre-recorded/artificial voice messages and/or automated dialing devices. I represent that I am the account holder for any telephone number(s) provided and am responsible for notifying the Provider of any changes or updates. I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages may be intercepted or received by unintended third parties and/or stored or archived by service providers

and system operators. Information included in such messages may include name, date/time of appointments, physician/practice name or specialty, patient account number, or other information related to financial obligation or services. Message and data rates may apply. I understand that I may opt out of these communications at any time by notifying Oncura Health in writing.

For assistance: contact **Oncura Health** at **323.254.0046**

☐ I consent to email or text communications for the purpose of treatment, payment, education, or operations

☐ I consent to email or text communications for the purpose of marketing

10. USE AND DISCLOSURE OF INFORMATION

I consent to Providers using and disclosing health information about me for treatment, payment, healthcare operations, public health, and other purposes permitted by applicable law. Covered information includes history and physical records, emergency records, laboratory reports, pharmacy claims, physician and nurse notes, discharge summaries, genetic, psychological, psychiatric, intellectual disability, and substance abuse disorder information, and information about blood-borne diseases such as HIV and AIDS. Certain categories of sensitive information are further protected under California and federal law and will be disclosed only as permitted or required by law. Unless I notify the Provider in writing that I choose to opt-out, I consent to my health information being shared through Health Information Exchanges (HIEs) for permitted purposes.

California SB 81 (eff. September 20, 2025) Immigration Status & Place of Birth | Cal. Civil Code § 56.10
A patient's current or prior immigration status and place of birth are protected "medical information" under the CMIA. This practice is PROHIBITED from disclosing this information for immigration enforcement purposes except: (1) pursuant to a valid search warrant or court order from a California state or federal court; (2) as expressly authorized in writing by the patient; or (3) as otherwise permitted or required by law.

11. OTHER ACKNOWLEDGMENTS

Weapons / Explosives / Controlled Substances

I understand that if the practice believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may take appropriate action, including termination of the patient relationship, consistent with applicable law.

ACKNOWLEDGMENTS AND SIGNATURES

Acknowledgment of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities, which ensures that I am treated with respect and dignity without discrimination based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source, or any other basis prohibited by federal, state, or local law. I may provide an advance directive to the Provider and may request information about formulating one. I have the right to participate in decisions regarding my care and to voice complaints or grievances without fear of retaliation.

Initials: _____

Notice of Privacy Practices. I acknowledge receipt of the Notice of Privacy Practices, which describes how my health information may be used and disclosed under federal law and applicable California law, including HIPAA (45 CFR Parts 160 & 164), the CMIA (Cal. Civil Code §§ 56 et seq.), SB 81 (eff. 9/20/2025, protecting immigration status and place of birth), and AB 352 (eff. 7/1/2024, EHR segregation of sensitive services records). If I decline or am unable to acknowledge receipt, the practice may document its good faith effort to provide the Notice. I may contact the Privacy Officer designated on the Notice or file a complaint with the U.S. Department of Health and Human Services.

Initials: _____

General Acknowledgment. I have been given the opportunity to read and ask questions about this form, including the financial obligations and assignment of benefit provisions. My questions have been answered to my satisfaction and I am signing voluntarily. Signing does not affect my access to care or treatment. **Initials: _____**

I, the undersigned, as the Patient or Patient Representative, or for a minor/incapacitated Patient as the legal guardian, certify I have read and understand these Conditions of Service and have signed knowingly, freely, and voluntarily. No promises, assurances, or guarantees have been made regarding results of medical treatment. If insurance coverage is insufficient, denied, or unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient / Patient Representative Signature: **Date:**

Witness Signature and Title: **Time:**

Additional Witness Signature and Title (required for Patients unable to sign without a representative or Patients who refuse to sign)

Additional Signature and Title:

If you are not the Patient, please identify your relationship (check all that apply):

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Healthcare POA ☐ Guarantor ☐ Other:

Other Relationship (specify):

Legal Authorities: HIPAA Privacy Rule, 45 CFR §§ 160 & 164 • Cal. Civil Code §§ 56–56.37 (CMIA) • SB 81 (2025, eff. 9/20/2025) • Cal. Bus. & Prof. Code § 2290.5 (Telehealth) Cal. Welf. & Inst. Code § 14132.725 (Medi-Cal Telehealth) 42 CFR Part 2 (SUD Records) This form is a compliance template. Remove all yellow advisory notes, complete bracketed fields, and review with legal counsel before deploying.