CONSENT FOR MEDICAL TREATMENT

Welcome to the Whole Foods Market Medical and Wellness Center (the "Medical & Wellness Center"). Our goal is to provide you with medical and wellness services that will better support your overall health and well-being. By signing below, you are acknowledging that you have read or reviewed this "Consent for Medical Treatment" form and that you agree with the following statements and agree to receive these services in accordance with the following terms and conditions. **Please Note: Medical and Wellness Center cannot treat injuries related to a current or potential claim covered by Workers Compensation Insurance.**

My Acknowledgments and Consent:

I am providing my general consent to receive the medical and wellness services that my treating physician and other non-physician providers and assistants associated with the Medical & Wellness Center may deem necessary or advisable. I understand that these services will be provided by my treating physician or healthcare provider, Clinical Wellness Associates, P.C. (in California) and/or Clinical Wellness Group of Texas (in Texas) which is an independent contractor of WFM Medical and Wellness Centers, Inc. ("WFM MWC, Inc."), as well as other non-physician employees, associates, assistants, agents, and other health care providers and suppliers of WFM MWC, Inc. I understand (i) that such services may include diagnostic procedures, examinations, and treatment and (ii) that photographs, videotapes, digital, and other images may be made or recorded for treatment or payment purposes. I consent to the taking of pictures, videotapes or other electronic reproductions of my medical condition or treatment and the use of the pictures videotapes or electronic reproductions for purposes permitted by law. Under specific circumstances, I may be asked for separate consent prior to the taking of pictures, videotapes or other electronic reproductions of my medical condition or treatment and the use of those pictures. If the image could be directly used to identify me, I will be asked for authorization to use or disclose the image, unless it is for treatment or limited other activities consistent with applicable privacy laws.

I understand that it is the responsibility of the physician or other treating provider to obtain my informed consent when required for specific medical treatment and specific diagnostic or therapeutic procedures. **I also acknowledge that no warranty or guarantee has been made to me as to results or cures related to such services**. I am at least 18 years of age, an emancipated minor, or the parent/legal guardian of a minor under 18 years of age. (NOTE: Pursuant to applicable state law, minors may be permitted to consent to treatment for certain medical conditions.)

I understand that my treating physician or other provider is exclusively responsible for overseeing and managing my health and wellness service needs and that my treating physician or other provider is free to exercise his or her professional medical judgment as he or she deems appropriate based on such needs. I understand that my treating physician is not employed by WFM MWC, Inc. and that WFM MWC, Inc. is not responsible for the services provided or overseen by my treating physician. Further, I understand that WFM MWC, Inc. does not supervise or exercise any control over my treating physician and other non- physician providers and assistants and has no responsibility for the professional services delivered at the clinic.

I acknowledge that I have been given, and will consistently be given, the right to ask questions about the medical, health care, and wellness services provided or recommended by my treating physician. I understand that I have the right to decline any or all services recommended by my treating physician. I also understand that I may withdraw this Consent for Medical Treatment at any time before any treatment.

I agree that I am financially responsible to the Medical & Wellness Center for charges, if any, resulting from my

receipt of medical and wellness processes, treatment, and procedures not covered by the Whole Foods Market Medical Plan. I acknowledge that I am not being seen by the Medical & Wellness Center staff for healthcare services related to an injury covered by workers compensation insurance.

Participation in Social Media:

I understand that there will be opportunities to voluntarily participate in social media as related to the Medical & Wellness Center and its community including sharing my personal medical details with other Center patients. I also understand that none of my protected health information will be shared on these sites unless I have given my permission or have shared the information myself.

_________ (Initial if you wish to participate) I hereby consent to participate in social media related to the Medical & Wellness Center including, but not limited to participation in the Medical & Wellness Center's Facebook Page. I understand that my personal health information (including, but not limited to: name, gender, medical condition, picture, and age) may be disclosed. I also understand that by participating in social media I may ask a question to Center staff via social media in which any response may require disclosure of my Protected Health Information.

Enrollees in the Whole Foods Market Whole Health Plan with HSA:

As described in the Benefits Enrollment Guide you will be billed for clinical services received at the Medical & Wellness Center up to the applicable deductible/coinsurance if you or your dependents are enrolled in the Whole Foods Market Whole Health Plan with HSA. You will not be charged if you are utilizing health coaching services.

_________ (Initial if you are enrolled in the Whole Foods Market Whole Health Plan with HSA) I hereby understand that this plan is a high deductible health plan and that I will be billed for certain services as directed by the insurance plan requirements and the federal requirements of high deductible insurance plans.

Receipt of NPP:

I acknowledge that I have been given a copy of the Medical & Wellness Center's Notice of Privacy Practices ("NPP") and may receive duplicate copies of the NPP at my request.

My Certification:

My signature below certifies that I have read or reviewed the above "Consent for Medical Treatment" form and that I agree to accept such terms and conditions. I understand that the above described authorizations and consents will be valid and remain in effect as long as I attend or receive services from the Medical & Wellness Center, unless any such authorization or consent is revoked by me in writing before any treatment.

____
Print Patient's name

____
Signature of Patient

____
Date

If Consent for a minor under 18 years of age:

____
Print Parent/Legal Guardian Name

____
Signature of Parent/ Legal Guardian