



18 Titus Road, PO Box 1272
Washington, CT 06793

☎ (888) 852-2723

📠 (888) 952-2723

✉ info@evexiadiagnostics.com

EVEXIADIRECT CLINICIAN AGREEMENT AND PAYMENT AUTHORIZATION

The following is the EvexiaDirect Clinician Agreement and Payment Authorization between Evexia Diagnostics, Inc. (“EDI”), a wholly owned subsidiary of Evexia Holdings, Inc. (“Evexia”) and you, the clinician/client of EDI (“Clinician” or “Client”). Once a Client’s patient(s) register for the Evexia Direct program (“Registered Patients”), they will become party to a separate agreement that governs the relationship between the Registered Patients and EDI under EvexiaDirect. Throughout this agreement (hereinafter the “Agreement”), you will be referred to as “Client”, “You” or “Your” in the possessive.

GENERAL

EvexiaDirect is a payment program provided by EDI to its existing clients as an alternative to EDI’s standard client payment agreement. Under EvexiaDirect, a Client’s Registered Patients will pay EDI directly for lab tests/panels and/or Evexia Nutraceuticals products ordered by the Client, thereby removing the Client from the billing and payment process.

PLAN OPTIONS FOR EDI LAB TEST/PANELS

EvexiaDirect for EDI lab tests/panels is currently available under two options:

Under Option 1, the “Non-ASF Option”, EDI charges Registered Patients the published EDI Client Price for all EDI lab tests/panels. No Administrative Service Fee or “ASF” (defined below) is paid to the EDI Client. EDI does charge the patient a 5% Program Fee for all transactions.

Under Option 2, the “ASF Option”, EDI charges Registered Patients the published EDI Patient Pricing for all EDI lab tests/panels. EDI will pay Client an Administrative Service Fee (“ASF”) for administering the EvexiaDirect Program to Client’s Registered Patients, which equals the difference between the EDI Patient Price and the EDI Client Price less the 5% Program Fee. EDI will pay an ASF to Client for each Registered Patient laboratory testing requisition generated through EDI for all completed laboratory tests. Generally, Client will be paid on a monthly basis by the last day of the month, following the close of the previous calendar month, and following EDI’s receipt of the applicable lab testing fees along with confirmation of the completed test results and subject to the 5% Program Fee.

Clients may set the EDI Patient Price for all custom panels designed by the Client. As with standard EDI lab tests/panels, EDI will pay Client an Administrative Service Fee (“ASF”) for administering the program, which equal to the difference between the EDI Patient Price and the EDI Client Price for these custom panels less the 5% Program Fee.



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EVEXIA NUTRACEUTICALS PRODUCTS

A Registered Patient is billed directly and pays the published retail price for all Evexia Nutraceuticals products.

CONDITIONS OF USE

In order to enroll in the EvexiaDirect program, the Client must acknowledge and agree as follows:

NOT AVAILABLE FOR BENEFICIARIES OF INSURANCE OR MEDICARE/MEDICAID

Client will not use EvexiaDirect for any lab tests/panels that are subject to, or will be paid by, any insurance company or any federal health care program, including Medicaid or Medicare, and Client agrees not to refer any patient to the program who may be expecting any federal health care program to reimburse them for fees paid to EDI. Patients who are eligible for Medicaid or Medicare may still use Evexia Direct, but only if they agree to waive any federal health care program coverage for the lab panels/tests administered under EvexiaDirect.

PAYMENT AUTHORIZATION AND ENTIRE AGREEMENT

EDI requires payment through either Automatic Withdrawal (ACH) via a valid U.S. financial institution checking account or by way of Visa, MasterCard, Discover or American Express credit cards. This is a legal agreement between the Client and EDI, stating the terms that govern Client's payment obligations to EDI. This Agreement, together with all updates, additional terms, and all of EDI's rules and policies, collectively constitute the payment Agreement between the Client and EDI. This version of the EVEXIA-DIRECT AGREEMENT AND PAYMENT AUTHORIZATION supersedes all previous versions. Client must accept and abide by these terms as presented. Changes, additions, deletions are not acceptable, and EDI may terminate your account for noncompliance with any part of this Agreement. This Agreement must be signed in order for the Client to enroll in EvexiaDirect.

COMPLIANCE WITH STATE AND LOCAL LAW

Client is solely responsible to ensure that the EvexiaDirect program is in full compliance with all applicable state and local laws as well as any professional or organizational rules or regulations. EDI takes no responsibility if Client's participation in the EvexiaDirect program is in violation of any of said laws, rules, or regulations.



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METHOD OF PAYMENT

A valid credit card or U.S. financial institution checking account number must be on file with EDI at all times for the Client. Either method of payment requires that Client be the authorized signer on the account(s) and that EDI is authorized to keep this information on file. Client acknowledges that by signing this document, Client is authorizing EDI to bill Client's account for any service rendered should EDI not be able to realize payment directly from Client's Registered Patient after 15 days of collections activities.

REFLEX AND CASCADING TESTS

Occasionally, the results of a test ordered by a Registered Patient may automatically trigger follow-on testing of the same specimen or specimens, otherwise known as "Reflex" or "Cascading" tests. These tests are typically billed directly to Evexia 30-90 days after the original tests are ordered.

Registered Patient will be required to authorize EDI to bill Registered Patient for these Reflex or Cascading tests up to a maximum amount of \$500 if these Reflex or Cascading tests are triggered and billed to Evexia. As with all tests ordered by Registered Patients, Client is authorizing EDI to bill Client's account for any Reflex or Cascading tests billed to Evexia on behalf of Client's Registered Patient if EDI is not able to realize payment directly from Client's Registered Patient after 15 days of collections activities.

REJECTED PAYMENTS

A chargeback of an authorized credit card charge will be subject to a \$50.00 administrative fee. Two or more chargebacks in a twelve-month period may result in the termination a Registered Patient's account. In like manner, a rejection of an authorized ACH draft will be subject to a \$50.00 administrative fee. Two or more rejected ACH drafts in a twelve-month period in a may result in the termination of a Registered Patient's account. Client acknowledges that by signing this document, Client is authorizing EDI to bill the Client's account for any chargeback or rejected ACH draft fees should EDI not be able to realize payment directly from Client's Registered Patient after 15 days of collections activities.

TERMINATION

Client may terminate enrollment in the EvexiaDirect program at any time in writing by using the appropriate Termination Form which can be obtained by calling Client services at 888-852-2723. Client is financially responsible for all services ordered and laboratory tests performed through client's EDI account(s), even though Client has requested termination of said account.

REFUNDS

EDI only charges for services rendered. EDI will automatically refund any Client order that is not completed within thirty (30) days subject to a \$15 administrative fee. Refunds for account over-payments will be issued to Clients as required. Please contact our Accounts Receivable Business Office at 888-852-2723 with any questions regarding the invoice.



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Option 1 (No ASF)

If you are selecting option 1, please fill out the information below and fax this form to our client success team at 888-952-2723.

Other Information: (will be on patient notifications)

Office Hours: _____

Client Name: _____

Client Signature: _____



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Option 2 (With ASF)

If you are selecting option 2, please fill out the information below and fax this form to our client success team at 888-952-2723.

ACH Information for ASF (**option 2 only**) Participation: _____

Name of Bank or Organization: _____

Type of Account (Checking or Savings): _____

ABA Routing Number: _____

Account Number: _____

Other Information: (will be on patient notifications)

Office Hours: _____

Client Name: _____

Client Signature: _____