ADVANCED THERAPY SOLUTIONS, INC.

Membership Agreement

By signing this membership agreement, you agree that you are responsible for following these guidelines. If you do not follow these guidelines, you will be terminated from membership and we will refuse service to you.

- All transactions for the product obtained at our facility and/or delivery service is final, and there are no refunds.
- As required by California Law, you must present your medical marijuana recommendation and a valid California driver's license or ID with every transaction. Also, as required by California Law, all patients must carry their doctor's recommendation on their person when traveling from location to location with medicine. Patients may be subject to Federal Laws regarding the possession or use of marijuana.
- No cell phone use is allowed with in the collective area. All cell phones must be put away and out of sight.
- You agree that you will use marijuana as a medicine and will not abuse it, transfer it, or sell it to anyone else.
- You will store your medical marijuana, or any substrate in a safe place that is out of the reach of children.
- When you have completed your transaction you agree to not loiter on the premises or within 1000 feet of the Collective for any reason. You must also arrive and leave alone.
- No marijuana shall be used in any way on the premises or within 100 feet of the Collective.
- Members must be considerate of our neighbors. Any complaints will be dealt with a zero tolerance policy and your membership will be terminated.
- You agree not to divert marijuana for non-medical purposes under any circumstances.
- We allow only one visit per patient or primary caregiver per day.
- The sale, resale, barter, or distribution of the medical marijuana to non-qualifying individuals is a crime.
- You allow the collective to grow medical marijuana on your behalf.
- This collective reserves the right to inspect all bags and packages entering the facility. We request that all packages and bags remain either in the lobby or in your vehicle.

You are advised to consult with your doctor as to dosage and frequency of use of the medication.

Any member of law enforcement who is a patient must disclose this fact before signing this membership agreement and becoming a member of this collective. Otherwise, by entering the premises of the collective and/or trying to obtain medical marijuana from our delivery service (if applicable), you promise, state, and affirm under penalty of perjury under the laws of the State of California, that you are not a member of, affiliated with, nor employed by any law enforcement department, entity, and/or agency.

This collective/dispensary reserves the right to refuse service to anyone at any time at our discretion and may terminate membership of any patient for any reason.

As a condition of entering our facility and/or by utilizing such medicine/herbal marijuana and related products as you may obtain, you , your heirs, and those with you expressly and forever release our Dispensary/Collective/Delivery Service, it's owners, landlord, operators, managers, employees, agents, attorneys, growers, providers, wholesalers, officers, directors, and members from and against any and all lawsuits, alter-ego lawsuits, demands, charges, or claims with reference to the strength, potency, purity, toxicity, and/or appropriateness for your condition of any marijuana and related products you may obtain at our facility and/or delivery service; further, that you knowingly waive the provisions of civil code section 1542 which states in pertinent part that "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor".

As a condition of entering our facility and/or by utilizing such medicine/herbal marijuana and related products as you may obtain, you, your heirs, and those with you expressly and forever waive any and all claims now known, or discovered at any time in the future due to, related to, or arising from your storage or handling of medical marijuana or any other product/herb/food/oil/concentrate you may obtain at our facility and/or through our delivery service. KEEP ALL MEDICINE FAR, AWAY FROM CHILDREN OR ANYONE ELSE, UNDER LOCK AND KEY, ANY DEVIATION FROM THIS RULE IS DONE AT THE SOLE RISK AND RESPONSIBILITY OF THE PATIENT.

You agree that as a Patient Member of our collective and/or delivery service, to abide by these rules and regulations.

I have read and agree to the above rules and regulations and;

- I have been diagnosed with a serious illness for which cannabis provides relief and I have received a recommendation or approval from my licensed California physician to use cannabis.

ADVANCED THERAPY SOLUTIONS, INC. OPERATES STRICTLY UNDER THE LEGAL FRAMEWORK ESTABLISHED BY THE COMPASSIONATE USE ACT OF 1996 (CALIFORNIA HEALTH AND SAFETY CODE SECTION 11362.5), SENATE BILL 420 (2003) (HEALTH AND SAFETY CODE SECTIONS 11362.5, 11362.765, & 11363.775).

· I understand my contributions for medicine(s) I may acquire from this collective and/or delivery service are used to ensure continued operation and that this transaction in no way constitutes commercial promotion.

· The monies I donate are to help the collective and/or delivery service continue to operate, maintain employees and a location and/or vehicle(s), and the associated cost and expenses of providing its members with medical marijuana for their medicine needs.

· The collective and/or delivery service may cultivate, obtain, transport, and possess cannabis on my behalf.

· I designate the collective and/or delivery service as my provider for medical marijuana.

· I authorize the collective and/or delivery service to contact my physician, and I authorize my physician to verify my recommendation to the collective and/or delivery service.

· I agree that I consistently rely upon the collective and/or delivery service as the exclusive source of my cannabis medicine (except such medicine that I may cultivate individually).

· This designation shall remain in effect for 12 months, until the expiration of my recommendation, or until I revoke my designation in writing by certified mail, return receipt requested, whichever comes first.

➡ Signature: _____ Date: _____

Patient Information (please print)

Your Full Name: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email address: _____

Driver's License/ID#: _____

MMJ State ID #: _____

ADVANCED THERAPY SOLUTIONS, INC.
HIPAA/CMIA AUTHORIZATION

Member Name: _____

Date of Birth: _____

➡ Signature of Patient:_____

Date: _____

I am either the Patient named above or the Patient's legally authorized representative.

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320(d) and 45 C.F.R. § 160-164, and/or information governed by the California

Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code § 56-56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c).

Pursuant to HIPAA and/or CMIA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse to ADVANCED THERAPY SOLUTIONS, INC.

The purposes of the usage and disclosure shall include determinations regarding my qualification to use medical marijuana and monitoring my health care to protect my legal rights where I reside.

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

I understand that I may refuse to sign this Authorization. I also understand that my health care provider cannot deny or refuse to provide treatment, payment, and enrollment in a health plan, or eligibility of benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it; however, I do not authorize such secondary disclosure.

The authority given to the persons or parties named above shall supersede any agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

I have read and understand the information in this Authorization form.

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