RELYMD| INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

This form is intended to obtain your permission and consent to participate in a telemedicine consultation and receive telemedicine services.

Having a condition requiring health care, or being responsible for an individual requiring health care, I hereby consent to diagnosis and the provision of such care via videoconference. I recognize that while this treatment approach provides the benefits of reduced waiting time and cost and allows treatment at home or another location of my choosing, there are inherent limitations to this approach. I acknowledge that the **RELYMD** medical provider will not be in the room with me to conduct a physical examination. I also acknowledge that the effectiveness of this treatment interaction will depend on a full disclosure of a medical history and symptoms to the **RELYMD** medical provider, and that failure to do so could result in adverse drug reactions, allergic reactions, or other medical problems. I acknowledge that the videoconference interface may not give the **RELYMD** medical provider the same information that would be available during an in-person examination, and that this could limit or affect the **RELYMD** medical provider's assessment or diagnosis of a condition and recommended treatment.

I understand that these limitations necessarily restrict the conditions that can be treated by **RELYMD**, and that I may be referred to a primary care physician, a local emergency department, or some other medical facility prior to receiving any diagnosis or care. I understand that if the **RELYMD** medical provider does provide a diagnosis and treatment to me or the individual for whom I am responsible, I may still be encouraged to seek follow-up care from a primary care provider or a specialty physician.

I understand that the medical providers staffing **RELYMD** are not employed by **RELYMD**, and that each provider will identify him- or herself at the beginning of every consultation. I further understand that I, or the person for whom I am responsible, must be physically located in a state where the provider is licensed to initiate a consultation on **RELYMD**.

I understand that if I am employed by a health care organization, the service agreement my employer has arranged provides that the medical record created as a result of any **RELYMD** telemedicine consultation may be uploaded into an existing electronic medical record, or prompt the creation of a new electronic medical record, to facilitate my future healthcare needs. I further understand that if I do not want the record of my telemedicine consultation added to a medical record, I need to contact **RELYMD** at privacy@relymd.com to obtain an alternative access to **RELYMD** before I begin my consultation.

I recognize that treatment by **RELYMD** is reliant upon a working Internet connection and computer or mobile device. In the event of an equipment or Internet failure, or if the **RELYMD** medical provider experiences an equipment or Internet failure, the consultation may be interrupted or terminated. In the event that this occurs, I will attempt to reestablish the online connection with **RELYMD**. If the online connection cannot be reestablished, I will call (855) 955-0948 to speak directly with a **RELYMD** medical provider.

I recognize that this **RELYMD** consultation is not taking place in a physician's office, and that, while the **RELYMD** medical provider is conducting his or her examination from a HIPAA-compliant secure location, I am responsible for preserving my (or the patient's) personal privacy during this consultation. I acknowledge that privacy is not assured if I choose to engage **RELYMD** from a public location, or through an unsecure Internet connection.

In the event that the patient experiences an adverse reaction to the treatment prescribed during the **RELYMD** consultation, I acknowledge that I will need to seek follow-up care from a primary care physician, or a local urgent care or emergency department. I understand that **RELYMD** does not assume responsibility for the patient's continued medical care or treatment.

Patient's Certification, Assignment of Insurance Benefits, and Guaranty of Payment

I understand that full payment of a co-payment is due at the time of service for myself, and any person for whom I am financially responsible.

I understand that the information given by me in applying for payments for any insurance benefit is correct. I hereby authorize payment of hospital insurance or other third-party benefits, including major medical, directly to **RELYMD**.

I recognize that telemedicine services are not always covered by applicable governmental benefits (Medicare/Medicaid) or private health care insurance. I understand that I am financially responsible for, agree to pay and guarantee payment in full of any and all charges for services provided to me, or to any person for whom I am financially responsible, by **RELYMD** medical providers. I understand that a bill for any unpaid portion of the visit will be sent to the address on file unless I complete a request for the bill to be sent to an alternate address.

In the event that I do have insurance coverage for telemedicine, I authorize **RELYMD** to act as attorney-in-fact (act on my behalf) with regard to: (1) collection of benefits from any responsible third party through whatever means necessary; and (2) endorsement of benefit checks made payable to me and/or Wake Emergency Physicians, PA. If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the cost of such collection efforts, including reasonable attorneys' fees.

I authorize payment of any refund that is due of any overpaid insurance benefits to be paid to the appropriate payor in accordance with my insurance policy conditions or any applicable benefit provisions where my coverages are subject to a coordination of benefits clause. With regard to any refund due to me, I authorize the immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by **RELYMD** through any healthcare provider. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Consent for Release of Medical Information

RELYMD is authorized to use and release medical information (except psychotherapy notes) obtained during this consultation for purposes of treatment, payment, research, and health care operations as stated in **RELYMD**'s *Notice of Privacy Practices*, to the following entities and/or individuals:

(1) third party insurance companies, managed care companies, Medicare, Medicaid, workers' compensation or other payors that I identify as possibly responsible for payment of the services that have been provided to me;

(2) groups or their agents subject to the Assignment of Insurance Benefits section of this consent;

(3) persons or agencies involved in processing applications for or determining my or the patient's eligibility for financial benefits, including replacement programs;

(4) any person or external review agency involved in reviewing, authorizing, or processing my or the patient's eligibility for health insurance coverage, payment of benefits or billing compliance for such potential payers that I identify;

(5) persons, physician practices, facilities, or agencies from which I have been referred and to which I am referred, that represent to **RELYMD** that I have been referred to them for treatment, that assist with identifying, or that are contacted concerning possible appropriate care for me or the patient during a hospital stay or after discharge;

(6) persons at my home, other designated location, or number that I provide (including telephone, e-mail or mail, follow-up calls or messages to me or my representative) concerning requests for a return call;

(7) family or persons that I represent are involved in my or the patient's care or that I allow to be present when information is communicated with me; and

(8) private physician, family physician, and/or medical group practice that I designate during registration.

(9) third parties for the purpose of research, whether non-commercial or commercial in nature, where data related to you or your care has been anonymized so that your identity is not capable of being determined from the data.

RELYMD is authorized, but not required, to obtain my prescription history from participating payors and pharmacies.

I understand that this consent will automatically expire in two (2) years. I understand that I may request restrictions on disclosure of any of the above health information by completing the **RELYMD** Request for Restriction of Health Information form. I also understand that I may revoke or discontinue my consent at any time by notifying **RELYMD** in writing, except to the extent actions have already been taken based upon my consent, including the disclosure of information to third party payors to seek payment for the care and treatment provided to me. I understand that information disclosed pursuant to this consent may be subject to re-disclosure and would not be protected under the terms of the federal privacy rule. I understand and agree to the above releases, authorizations, and assignments of benefits.

I have read this consent form in full and understand the information provided above. I hereby give my informed consent for the use of telemedicine by **RELYMD** and the healthcare providers providing this medical care.