

Bicycle Health Medical Group, P.A., and its affiliated medical groups (collectively, Bicycle Health) is committed to providing the best quality healthcare services.

General Consent to Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services and/or decline any and all treatments, even if against medical advice. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or advanced practice clinician (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Informed Consent for Telehealth Services

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider and a patient at different locations to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care. This **"Telehealth Informed Consent"** informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Bicycle Health Medical Group, P.A. ("**Group**"), and the Group's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law, and will establish a provider-patient relationship in accordance with the laws and rules in the applicable state.

Bicycle Health, Inc. does not provide the Services; it performs administrative, payment, and other supportive activities for Group and our Providers.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
 - o asynchronous communications
 - o two-way interactive audio in combination with store-and-forward communications; and/or
 - o two-way interactive audio and video interaction
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;
- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;
- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 8 hours a day, 5 days a week.
- Convenient access to follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by sending a message via the Spruce app.
- More efficient care evaluation and management. You can expect a response within 1 hour during the business day by a trained health coach for any administrative and/or care coordination issues. Your provider will typically respond to any non-emergent messages within 1 business day during the week or during the next business days over weekends and holidays.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **Our providers do not address medical emergencies. If you believe you are experiencing a medical emergency, You should dial 9-1-1 and/or go to the nearest emergency room. please do not attempt to contact Bicycle Health, inc., GROUP, or your Provider. After receiving emergency healthcare treatment, you should visit your local primary care PROVIDER.**
- Our Providers are an addition to, and not a replacement for, your local primary care provider.

Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate one if you do not.

- Group does have any in-person clinic locations.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Group at (866) 284-4648 or info@bicyclehealth.com.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a re-scheduled telehealth consult or an in-person meeting with your local primary care doctor
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Patient Acknowledgments:

I further acknowledge and understand the following:

1. Prior to the telehealth visit, I have been given an opportunity to select a provider as appropriate, including a review of the provider’s credentials, or I have elected to visit with the next available provider from Group, and have been given my Provider’s credentials.
2. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.
3. I may elect to seek services from a medical group with in-person clinics as an alternative to receiving telehealth services.
4. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.
5. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record.
6. Group will take steps to make sure that my health information is not seen by anyone who should not see it. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state.
7. Dissemination of any patient identifiable images or information from the telehealth visit to researchers or other educational entities will not occur without my affirmative consent.
8. There is a risk of technical failures during the telehealth visit beyond the control of Group. I AGREE TO HOLD HARMLESS GROUP AND ITS EMPLOYEES, CONTRACTORS, AGENTS, DIRECTORS, MEMBERS, MANAGERS, SHAREHOLDERS, OFFICERS, REPRESENTATIVES, ASSIGNS,

PARENTS, PREDECESSORS, AND SUCCESSORS for delays in evaluation or for information lost due to such technical failures.

9. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.
10. Persons may be present during the telehealth visit other than my Provider in order to operate the telehealth technologies. If another person is present during the telehealth visit, I will be informed of the individual's presence and his/her role.
11. My Provider will explain my diagnosis and its evidentiary basis, and the risks and benefits of various treatment options
12. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting Group by sending a message in the Spruce app or sending an email to info@bicyclehealth.com. A copy will be provided to me at reasonable cost of preparation, shipping and delivery.
13. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that I can log into my "Portal" <https://18731.portal.athenahea...> at anytime to access, or review my health information.
14. There is no guarantee that I will be issued a prescription and that the decision of whether a prescription is appropriate will be made in the professional judgement of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.
15. There is no guarantee that I will be treated by a Group provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.

Additional State-Specific Consents: The following consents apply to patients accessing Group's website for the purposes of participating in a telehealth consultation as required by the states listed below:

Iowa: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, [here](#).

Idaho: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, [here](#).

Indiana: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, [here](#).

Kentucky: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here: <https://kbml.ky.gov/grievances...>

Maine: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, [here](#).

Oklahoma: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here:

Oklahoma Board of Medical Licensure and Supervision: <http://www.okmedicalboard.org/complaint>

Oklahoma Board of Osteopathic Examiners: <https://www.ok.gov/osboe/faqs.html>.

Texas: I have been informed of the following notice:

NOTICE CONCERNING COMPLAINTS -Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018,Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353, For more information, please visit our website at www.tmb.state.tx.us.

AVISO SOBRE LAS QUEJAS- Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353, Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us

Vermont: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here:

Vermont Board of Medical Practice: [Here](#).

Vermont Board of Osteopathic Examiners: [Here](#).

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices resides at www.bicyclehealth.com/legal/npp. It provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by sending us an email at info@bicyclehealth.com.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent in writing, and we will honor your revocation except where we have already made releases in

reliance on your prior consent.

Notice of Potential Information Loss Due to Technological Failure

Information transmitted through telehealth technology may be lost due to technological failure beyond the control of the Group which can result in delays in treatment or other adverse consequences. I agree to hold-harmless Bicycle Health and its employees, contractors, agents, directors, members, managers, shareholders, officers, representatives, assigns, parents, predecessors, and successors for consequences of information loss due to technological failure.

Consent to Obtain Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. I understand this may not be a complete history, and I agree to provide a complete account of my own medication filling and use history to my Provider.

Assignment of Benefits

I request and permit my insurance company or benefit plan to pay directly to Bicycle Health Medical Group, money due for health care services, supplies and equipment under the terms of my insurance policy or benefit plan. I understand that I may be responsible for payment in full of any amount due that is not covered or paid for by my insurance policy or benefit plan. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

Notice of Financial Responsibility

I have received a *Financial Responsibility Agreement* that describes the cost of Bicycle Health services, and I have reviewed and understand the contents of this agreement.

Release of Information and Statement of Assistance

1. I permit Bicycle Health Medical Group, to provide my insurance company or benefit plan with any information necessary for Bicycle Health Medical Group to receive payment for services, supplies, and equipment.
2. I permit Bicycle Health Medical Group, and/or its attorneys to request, on my behalf, any information related to my health insurance policy or benefit plan (including, but not limited to, proof of my insurance or benefit plan). This information may be given directly to Bicycle Health Medical Group or its attorneys.
3. I permit Bicycle Health Medical Group, and/or its attorneys, to file, on behalf of themselves and on my own behalf, claims for benefits and/or appeals of any denied claims.
4. I agree to assist Bicycle Health Medical Group in collecting benefits that may be due or payable under

- my insurance policy or benefit plan for the services, supplies, and equipment provided.
5. I agree to provide any additional information needed to process the claim for payment.
 6. I agree that Bicycle Health Medical Group may take action in my name against my insurance company or benefit plan to receive any benefits that may be due or payable under the insurance policy or benefit plan.

Consent to receive Protected Health Information via Email and SMS

I hereby consent and state my preference to have my Bicycle Health Medical Group physician and other staff at Bicycle Health Medical Group communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Consent to Receive Texts and Emails from Bicycle Health, Inc. and its Business Partners

By providing your cell phone number and email address to Bicycle Health, Inc. ("Bicycle Health"), you are agreeing to be contacted by or on behalf of Bicycle Health and our business partners identified below at the email address and the telephone number provided, including emails to your email address and text (SMS) messages to your cell phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice and prerecorded messages, to providing you with marketing and promotional materials relating to Bicycle Health's products and services, and products and services of the identified business partners. You may opt-out of receiving text (SMS) messages from Bicycle Health or its subsidiaries at any time by replying with the word STOP from the mobile device receiving the messages. You need not provide this consent in order to purchase any products or services from Bicycle Health. However, you acknowledge that opting out of receiving text (SMS) messages may impact your experience with the service(s) that rely on communications via text (SMS) messaging.

Business Partners: Bicycle Health Medical Group P.A. and Bicycle Health Provider Group Inc.

Treatment Agreement

- 1. I agree to be civil and never to intimidate, threaten, or verbally abuse Bicycle Staff.** We understand and encourage being open and showing emotion but do not tolerate hostility.
- 2. I agree never to sell, share or give any of my medication to another person.** We can't allow medication that we prescribe to be used in any way other than directed by your medical provider. Sharing or selling medication is dangerous, illegal, and cause for termination of further prescriptions. We're always happy to work with your friend or loved-one to enroll in treatment instead.
- 3. I agree to take my prescribed medication exactly as directed and to notify my provider if directions are unclear or I'm unable to follow them for any reason.** Never improvise or guess! We're always here to support you, and so is your pharmacist. Do not increase or decrease your dose unless directed to do so by your provider.
- 4. I agree to notify my Bicycle Health provider anytime a new medication is prescribed by another medical provider.** We must review all other medication for safety when prescribed along with the treatment that we provide, and we consider their possible effect on drug test results.

5. I agree to provide complete and accurate answers to my Bicycle Health provider. Your provider is a trained specialist but can't read your mind! We make medical decisions to maximize your comfort and safety, and we rely on what you tell us to accomplish this. If we can't rely on the information you provide us, it may be unsafe to continue your treatment.

6. I agree to provide my own sample of urine or saliva for drug testing promptly within 24 hours when directed. Drug testing helps you to be accountable to your goals for treatment, and it helps us understand how well your treatment is working for you. We will not continue telemedicine treatment if drug screens are being delayed, forged, tampered, or deliberately or repeatedly caused to be inaccurate.

7. I agree not to fill any prescription for an opioid medication unless it is prescribed or specifically authorized by my Bicycle Health provider, except in a medical emergency. Other opioid medications are crucial for us to know about due to their impact on your Bicycle Health treatment.

8. I agree to provide at least 24 hours notice to reschedule an appointment, and I understand that medication refills will only be provided during scheduled appointments. We will never provide a buprenorphine refill outside of a video-appointment during business hours. Please plan accordingly.

9. I agree to work with my Bicycle Health provider toward the goal of stopping all illicit drug use. We ask all patients to work with us toward this goal which, based on your unique treatment plan and preferences may include working with a counselor, therapist, support group, mental health provider, or another type of treatment program to compliment care by your Bicycle Health provider. Our model works very well for most patients, but in the case where a patient is not progressing toward treatment goals we would refer to a more suitable program and discontinue telemedicine care.

10. I agree to notify Bicycle Health in advance when I am going to be unavailable to complete a random drug screen or medication count. We want you to be free to travel and enjoy your life. Give us a heads-up in advance when you will be unreachable or unable to complete a drug screen, and we'll accommodate all such reasonable requests. Exceptions to the advance notice requirement will be made for documented emergencies at the medical provider's discretion.

11. I agree to complete a medication count promptly within 24 hours when directed. Periodically we will verify that you have the correct number of tablets or films remaining which helps us understand that you're taking and storing the medication safely as directed. Counts may be performed by video or photograph, per instruction of Bicycle Health staff.

12. I agree to store my medication in a safe, secure place where it's not accessible to others and especially not accessible to children. In the event of medication loss or theft, a police report must be filed before we can consider replacing lost medication. A child who ingests buprenorphine may die from opioid overdose. If you are ever concerned about having a safe place to store your medication, talk to your provider who will advise you.

13. I agree to provide prompt notice to Bicycle Health of any change in my contact or payment information. We want to avoid any interruptions in your care that may be caused by difficulty reaching you, covering costs, or sending drug tests to old or invalid addresses. We won't know of changes unless you tell us, so do keep us informed.

14. I agree to read all materials and ask any questions needed to help me understand them before signing anything. Agreements like this one are designed to ensure you know all about our program and what we need from you to continue a safe, convenient, and long-lasting treatment relationship.

15. I agree not to openly display or use an illegal substance during my interactions with Bicycle Health staff or providers. We're happy to be able to serve patients in the comfort of their own homes. At the same time, telemedicine visits are also professional interactions like being in your medical provider's office. Please help us create an environment of respect and professional dignity during your visits.

16. I understand that my treatment plan is determined by my medical provider and will be modified based on my changing situation and needs. Your provider will develop the treatment plan collaboratively with you and will respect your preferences and decisions to every extent possible. Situations may occur when your preferred treatment is no longer medically safe. Failure to abide by this treatment agreement may lead your provider to determine that telemedicine-based buprenorphine is no longer safe and to refer to a different treatment setting.

17. I understand that Bicycle Health provides medical assessment, treatment, and needed support for that treatment which may include referral when needed. There are several options and settings for treatment of problematic opioid use, and payment does not obligate any Bicycle Health provider to recommend or provide a specific form of treatment such as buprenorphine. The appropriate treatment is always at the discretion of your provider.

I agree to adhere to all the conditions above. I understand the policies listed above and I agree to comply with this aspect of my treatment plan. I understand that the failure to comply with any of the conditions above will be grounds for the termination of my treatment with Bicycle Health Medical Group.

I certify that I have carefully read, understand, and agree to the terms above, and I consent fully and voluntarily to this agreement. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

Client Signature

Date