Patient Demographics

Patient Name:_____ Date of Birth:_____

Email:_____ Telephone:_____

If this form is being completed by an authorized representative of the patient:

Representative Name: _____

Representative Relationship: _____

Patient Consent Form:

[Patient/Patient's legal representative] (hereafter referred to as "I" or "me") agrees to permit authorized personnel of Valera Health, Inc. dba Valera Health or one or more of its affiliated entities or independent practitioners who work on behalf of any such entity (collectively, "Valera Health" or the "Company") to perform such diagnostic and therapeutic procedures that my treating physician(s) or other clinician(s) deem necessary for care. By signing below I agree to permit tests, photographs for treatment purposes, routine treatment as necessary, and services performed at the request of clinicians and/or physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks, and complications associated with such treatment or procedures and I have given my consent.

The below consent forms are intended to make you aware of treatment methods, risks, and limitations related to different methods of care, payment mechanisms when receiving professional clinical services from Valera Medical, P.A., Valera Medical, P.C. and/or and its affiliates (the "Medical Group") and its engaged providers ("Providers" or your "Provider"), and other information important to your experience with Valera Health, Inc. and Valera Medical, P.A.

Telehealth Informed Consent

I hereby consent to engage in telehealth with "Medical Group" to perform such diagnostic and therapeutic procedures that my treating physician(s) and/or clinicians deem necessary for care. I understand that "telehealth" includes the practice of health care delivery, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to our clinicians, including, but not limited to Physicians, Psychiatrists, Psychologists, Social Workers, etc.
Telehealth is also a viable option for those patients/patients whose symptoms may hinder or prohibit travel to a clinic or other setting. I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which a patient would otherwise be entitled.
2. The laws that protect the confidentiality of medical information also apply to telehealth. As such, I understand that the information disclosed during telehealth sessions is generally con-

fidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where a patient's mental or emotional state is an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my telehealth provider, that: the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I also understand that if my telehealth provider believes a patient would be better served by another form of therapeutic services (e.g. in-person services) the patient will be referred to a qualified provider who can provide such services. Finally, I understand that there are potential risks and benefits associated with any form of therapy and that despite my efforts and the efforts of my telehealth provider, a patient's condition may not improve, and in some cases may even get worse.
4. I agree to only have Telehealth services when I am using a secure internet connection.
5. I understand that a patient may benefit from telehealth, but that results cannot be guaranteed or assured.
6. I agree that I will not record, photograph, or video any sessions without the knowledge and consent of all parties.
7. I understand that I will be able to discuss with my Provider any recommended treatment plan and the purpose, potential risks and benefits of such treatment, and any test or prescription ordered for me and, if I have any concerns regarding any such treatment, test, or prescription recommended or administered by my Provider, I will be able to ask questions of my Provider.
8. I understand that Provider may not be able to offer me the treatment options I want, or may make treatment recommendations I don't feel are right for me. In such cases, I understand that I may decline such options and/or recommendations, and may need to seek treatment from other providers.
9. 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.
10. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that I can request access, amendments, or the opportunity to review my information.
11. 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 judgment of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.
12. There is no guarantee that I will be treated by a Medical 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.
13. If I am a guardian or parent of a minor who is a patient of the Medical Group, I understand that at least one adult caregiver should be available during the session (either in person or reachable by phone).
14. I understand that for the most effective treatment, the presence of others in the therapy space should be minimized to the extent possible.
15. I understand 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 Valera Health, Inc., Medical Group, or your provider. After receiving emergency healthcare treatment, you should visit your local primary care provider.
16. I have read and understand the information provided above regarding Telehealth, and all my

questions have been answered to my satisfaction.

17. I have read and understand the information provided in this document, I have also received and reviewed a copy of the Notice of Privacy Practices and discussed any questions, and all of my questions have been answered to my satisfaction.
18. I understand that, by accepting this Consent to Treatment, I am providing authorization for the Medical Group to treat me for as long as I seek care from Medical Group, or until I withdraw this consent to treatment in writing.

☐ **I agree to Telehealth services:** *I agree to Telehealth services, Valera Health's Service Agreement, Patient Rights & Grievance Process, Notice of Privacy Practices: Please note that these services will only be delivered should they be recommended and clinically appropriate.*

Text Messaging / Phone Contact

I authorize Valera Health and its affiliates to contact me by automated SMS text message for appointment reminders at the phone number provided during intake. I understand that message/data rates may apply to messages sent by Valera Health or its affiliates under my cell phone plan.
I acknowledge that I am under no obligation to authorize Valera Health or its affiliates to send text messages. I may opt out of receiving these communications at any time by emailing wellness@valerahealth.com. Please allow 2-3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include my or my child's first name, date/time of appointments, name of the provider or other pertinent information.
By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Valera Health and its affiliates to the phone number that I have provided.

_____ _____

(Signature of Patient / Legal Representative)[1] Date Signed

If Patient is a minor:

_____

Description of Relationship to Minor (E.g. Parent, Guardian)

☐ ***By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from providing consent on behalf of my child.***

[1] If other than the patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

Additional State-Specific Consents:

I confirm that I have been notified which state(s) my Provider is licensed to practice, and that I plan to attend sessions in the licensed state(s). Further, it is my responsibility to notify my Provider of any changes of my location more than 48 hours prior to the time of my next visit. The following consents apply to patients accessing the Medical Group's website for the purposes of participating in a telehealth consultation as required by the states listed below:

Alaska:
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.

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.

Rhode Island:
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.

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; Or, the Maine Board of Osteopathic Licensure's website, here.

New York:
I have been informed that I can find information on patient rights and how to report concerns of physician misconduct, 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; Or, the Oklahoma Board of Osteopathic Examiners' website, here.

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, 333 Guadalupe, 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, asi como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugia, 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 ; Or, the Vermont Board of Osteopathic Examiners' website, here.

I understand that Valera conducts visits primarily through video. I understand that in certain circumstances we may provide audio-only services if video is unavailable. If I elect to do audio-only services, I understand there are certain limitations relative to video visits (i.e., controlled substances will not be prescribed if sessions are audio-only). Provider can elect to refer to in-person care if determined that proper care cannot be given with audio only.

My services delivered by audio-only telephone will be billed to my health insurance plan. I am financially responsible for any applicable co-payments, coinsurance, and deductibles. I understand that not all audio-only health care services are covered by all health plans.

Credit Card-on-File Policy and Authorization

I acknowledge and agree that I have provided my credit card information to Valera Medical, P.A., Valera Medical, P.C., and/or its affiliates (collectively, the "Medical Group") that may be used by the Group for payment of fees and charges (collectively "Charges") I owe to the Medical Group. Charges include amounts owed or incurred with respect to services and treatment provided by the Medical Group, as well as (1) co-payments or deductibles in amounts ranging from $5 to $600 per visit, as determined by the terms of my health insurance coverage, and (2) no-show, cancellation and rescheduling Charges currently in the amount of $50 per missed visit as outlined in the Assignment of Benefits, that I have separately read and signed, which amount may be changed by the Medical Group in the future with advance notice to me, not to exceed $50 without my prior written agreement. I understand the Medical Group can charge my credit card for amounts in excess of these amounts and ranges, provided that the Medical Group will provide me with advance notice of such Charges and amounts no less than ten (10) days prior to the date the Medical Group charges my credit card. Any written notifications to me from Medical Group regarding this authorization or Charges hereunder can be made by mail.

I authorize the Medical Group to use my credit card information to process and pay for all Charges that I incur with respect to the Medical Group. I represent and warrant that all information I have provided or will provide to the Medical Group, and contained herein, is and will remain current and accurate. I further agree that in the event my credit card becomes invalid, I will provide the Medical Group with new valid credit card information upon request to be charged for the payment of any outstanding amounts or balances owed to the Medical Group. In the event the Medical Group is unable to obtain payment through the credit card identified herein, I agree to be personally responsible for all such Charges.
This authorization will expire when I am no longer a patient of the Medical Group and have paid or otherwise satisfied all Charges owed to the Medical Group. I understand that I may revoke this authorization at any time by contacting billing@valerahealth.com and I acknowledge that the Medical Group will understand that such revocation indicates my intent to terminate treatment with the Medical Group.

☐ **ACCEPT.** By checking this Box, I certify that I have carefully read and understand the foregoing **"CREDIT CARD ON FILE POLICY AND AUTHORIZATION"** and have received a copy thereof.

_____ _____

(Signature of Patient / Legal Representative)[2] Date Signed

If Patient is a minor:

_____

Description of Relationship to Minor (E.g. Parent, Guardian)

☐ ***By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from providing consent on behalf of my child.***

[2] If other than the patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

Assignment of Benefits

I hereby assign to Valera Medical, P.A., and its affiliates, Valera Medical, P.C., and Valera Medical Corporation (collectively, "Medical Group") all my right, title, and interest in any and all health insurance or other health care benefits payable to me or on my behalf by any insurance payer, including Medicare, private insurance and any other health plan for medical treatment rendered by Medical Group. The assignment will remain in effect until revoked by me in writing. I authorize the release of pertinent information necessary to process my medical claim. I also authorize direct payment to Medical Group of all insurance benefits payable to me for such medical treatment. In the event an insurance payer pays me directly, I agree to immediately pay such amounts to Medical Group.

I understand that my insurance payer may pay less than the actual bill for services. I acknowledge that I am still responsible for paying Medical Group for any and all amounts not paid by my insurance payer, including non-covered charges and all copayments, coinsurance, and deductibles. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. In the event any collection action is necessary to collect amounts I owe to Medical Group, I agree to pay all expenses associated with such action, including but not limited to collection agency fees and attorneys' fees.

I acknowledge that:

- There is a $50 charge if I don't show up to my scheduled appointment, or if I cancel or reschedule within 48 hours of the scheduled time.This applies to all patients except those enrolled under Medicaid. The Group will charge the card on file within 14 days of the appointment date.
- If I am more than 15 minutes late to my appointment, it will be considered a no-show. I will have to re-schedule my appointment with my provider.
- If I cancel or reschedule my appointment prior to 48 hours before the scheduled appointment, there is no financial charge or penalty.
- If I no-show or cancel for two consecutive appointments or when missed appointments contribute to at least 50% of the overall scheduled appointments during a six (6) week period, I will be discharged from the service. If I wish to restart services, we cannot guarantee that you will be matched with the same provider or at your previously selected appointment time.
- I am required to place a credit card on file, which will be charged for any copays and/or deductibles and coinsurance. Under certain circumstances, the provider on the claim submitted to my insurer may be different from the provider who rendered the services. The name listed is the supervisor of my provider. Valera Medical PC will charge the card on file within 14 days of the appointment date.

☐ **ACCEPT**. By checking this Box, I certify that I have carefully read and understand the foregoing "**ASSIGNMENT OF BENEFITS**" and have received a copy thereof.

_____ _____

(Signature of Patient / Legal Representative)[3] Date Signed

If Patient is a minor:

_____

Description of Relationship to Minor (E.g. Parent, Guardian)

☐ ***By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from providing consent on behalf of my child.***

[3] If other than the patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

Group Therapy Session Informed Consent

Medical Group provides its patients with the ability to engage in group therapy sessions led by a Provider in a group setting. This Group Therapy Session Informed Consent ("Group Therapy Consent") describes how Medical Group expects its patients engaging in group therapy sessions to conduct themselves and what to expect. By accepting this Group Therapy Consent, I understand and agree to the terms and conditions of this Group Therapy Consent and agree to participate in group therapy sessions, which may occur virtually via telehealth or in-person.

Consent to Group Therapy:

Medical Group strives to maintain a positive and open environment during its group therapy sessions. The ability to engage and interact with the other patients in a group therapy session (each a "Group Therapy Patient" and collectively "Group Therapy Patients") in a safe and healthy manner is Medical Group's primary goal.

Medical Group appreciates that engaging in group therapy sessions can be uncomfortable and provoke unpleasant feelings such as anger, anxiety, frustration, sadness, and other unpleasant feelings. Similarly, we also understand that a group therapy session may lead you to have reactions, both positive and negative, to your fellow Group Therapy Patients or your group facilitator. If at any time, you feel that a group therapy session is not appropriate for you or you have an issue with another Group Therapy Patient, please contact the group facilitator or the Medical Group to discuss potential options.

Group therapy sessions are not designed for emergency or crisis situations. If you are experiencing an emergency or crisis situation, please dial 9-1-1 or a mental health hotline immediately.

Group Therapy Session Privacy:

- All Group Therapy Patients agree to keep group conversation and information about other Group Therapy Patients confidential. Medical Group takes measures to ensure that your private information remains confidential. However, despite these safeguards, a fellow Group Therapy Patient may share your confidential information. We encourage our Group Therapy Patients to be thoughtful about what they share

in a group therapy session and consider whether the information that will be shared is appropriate to be shared in a group therapy session or better to be shared in a more private setting such as a one-on-one appointment with a licensed clinician.

- Medical Group strives to create a safe environment where Group Therapy Patients can share and learn from one another. However, Medical Group cannot control everything said in the group therapy session that might be triggering or offensive to a Group Therapy Patient. We value your feedback, and we ask that you communicate with Medical Group if you would like to switch therapy groups or if you have any other concerns.

There are exceptions to these confidentiality requirements. In some situations, your group facilitator may be required by law to disclose information without your permission. For example, if the group facilitator believes that you are a danger to yourself or others or if Medical Group receives a subpoena or court order requiring us to disclose information, Medical Group may be required to share your information.

I agree, by clicking "Accept" below, that I have read, understand, and agree to this Group Therapy Consent. Failure to abide by the terms and conditions of this Group Therapy Consent could result in a suspension or termination of the ability to participate in group therapy sessions as a Group Therapy Patient.

☐ **Accept.** By checking the box, I agree to these terms and acknowledge the nature of sharing and participating in a group therapy session as set forth in the above **"GROUP THERAPY SESSION INFORMED CONSENT."**

_____ _____

(Signature of Patient / Legal Representative)[4] Date Signed

If Patient is a minor:

_____

Description of Relationship to Minor (E.g. Parent, Guardian)

☐ ***By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from providing consent on behalf of my child.***

[4] If other than the patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.