Informed Consent for Healthcare and Telehealth Services

I, or as the parent or authorized guardian acting on behalf of the patient named herein, hereby give informed consent for medical treatment and procedures to be administered by the healthcare professionals at Cloud Health Medical Group, P.A., Cloud Health Medical Group of California, P.C., Cloud Health Medical Group of New Jersey, P.A., and Cloud Health Medical Group of Kansas, P.C. (collectively "**Cloud Health Medical**").

By agreeing to this informed consent ("**Consent**"), you (or the patient you represent) have elected to receive Services via telehealth from Cloud Health Medical. If you have questions about whether telehealth is appropriate for the patient's medical condition, the associated risks, or the provider's credentials and professional background, please ask your Cloud Health Medical provider. Only use the Services if you have read this information and made an informed decision that the Services are right for you (or the patient). If you have any questions, please email us at **legal@usebridge.com**.

If signing as a Parent or Authorized Guardian: By completing this form online, I represent and warrant that I am the parent, legal guardian, or otherwise duly authorized representative of the patient named herein, and that I have full legal authority to execute this Consent on the patient's behalf. I acknowledge that my electronic signature carries the same legal force and effect as a handwritten signature.

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1. Nature of Consent

I understand that by signing this form, I am authorizing Cloud Health Medical and its healthcare providers to provide medical treatment, conduct diagnostic tests, and perform necessary procedures to diagnose and treat the patient's medical condition.

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2. Nature of Treatment

I acknowledge that Cloud Health Medical may employ a variety of medical treatments, including but not limited to examinations, diagnostic tests, medical procedures, surgeries, administration of medication, and the use of medical devices. I understand that alternative treatments, risks, and potential complications will be discussed with me (or the patient's authorized representative) before any procedures are performed.

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3. Telehealth Services

Telehealth services involve interactive video conferencing equipment and devices that allow a healthcare provider to deliver health care services from a location different from the patient's location. I confirm that I have read this form (or had it explained to me) and understand the following:

a. The patient will not be physically in the same room as their healthcare provider during the visit. I will be informed about and asked for consent before any other Cloud Health Medical staff or trainees actively assist the healthcare provider during the visit.

b. There are risks and consequences associated with telehealth services, including but not limited to:

- Disruption of the appointment caused by technology failures;
- The limited ability of the healthcare provider to respond to emergencies during the visit;
- Interruption or violations of confidentiality by unauthorized individuals. While Cloud Health Medical takes all reasonable steps to secure telehealth visits and breaches are very rare, no technology is completely secure;
- The possibility that the patient or provider decides the video conferencing connection is not adequate and needs to be stopped, switched to an alternate approved platform, or rescheduled; and
- The possibility that during a telehealth visit, the provider may not identify medical conditions that might otherwise be identified during an in-person visit.

c. The patient (or their authorized representative) has the right to refuse or stop participating in a telehealth visit, and any refusal will be noted in the medical record. Refusal may impact eligibility for future care or treatment at Cloud Health Medical.

d. The laws that protect the privacy and confidentiality of health information apply to telehealth services.

e. Health information may be shared with other individuals for scheduling and billing purposes.

- Health plan payment policies for telehealth visits may differ from policies for in-person visits.
- The patient is responsible for any out-of-pocket costs such as copayments or coinsurance applicable to telehealth visits.

f. During the telehealth visit, the patient must be physically located in a state where their provider is licensed, or the visit will not be able to proceed and will need to be rescheduled. If the patient is in a state other than the state previously provided, I will notify the provider's office before the visit to confirm availability.

g. All questions about telehealth services have been answered to my satisfaction. The risks, benefits, and alternatives to telehealth visits have been shared in a language I understand.

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4. Risks and Benefits

I understand that all medical treatments and procedures carry certain risks and potential benefits. While Cloud Health Medical will take necessary precautions to minimize risks, I acknowledge that no guarantees or assurances can be made regarding the outcome of any treatment or procedure.

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5. Privacy and Confidentiality

I acknowledge that Cloud Health Medical is committed to protecting the privacy and confidentiality of the patient's personal health information in accordance with applicable laws and regulations. I authorize the collection, use, and disclosure of health information for the purposes of treatment, payment, and healthcare operations.

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6. Financial Responsibility

I understand that the patient (and I, as guarantor where applicable) is financially responsible for all medical services rendered by Cloud Health Medical. I agree to pay all charges for services not covered by insurance, including deductibles, co-pays, and any outstanding balances.

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7. Right to Refuse or Withdraw Consent

I (or the patient) can refuse or withdraw consent for medical treatment at any time. I understand that this decision may have consequences and that I should discuss any concerns or questions with the healthcare provider.

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8. Communication and Follow-Up

I understand the importance of open and honest communication with the healthcare provider. I agree to provide accurate and complete information about the patient's medical history, current medications, allergies, and other relevant details. I understand I should follow any post-treatment instructions and attend follow-up appointments as recommended.

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9. Authorization for Medical Decision-Making

I authorize Cloud Health Medical and its healthcare providers to make necessary medical decisions on the patient's behalf if the patient cannot do so, based on their professional judgment and in accordance with applicable laws and regulations. If I am a parent or authorized guardian, I affirm that I hold the legal authority to make such decisions on the patient's behalf.

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10. Choice of Pharmacy Services

If a prescription is issued as a result of the Services, the patient may choose to have it fulfilled through a pharmacy of their choice. I consent to Cloud Health Medical sending and disclosing to that pharmacy all information provided, health care records, and other applicable health care and personal information (such as name, location, and demographic information) so that pharmacy services may be received.

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11. Additional Patient Consents

a. If the patient is experiencing a medical emergency, I will direct the patient to dial **9-1-1** immediately. The provider is not able to connect the patient directly to local emergency services.

b. I may elect to seek services from a medical group or provider with in-person clinics as an alternative to receiving telehealth services.

c. The patient (or their authorized representative) has the right to withhold or withdraw consent to the use of telehealth at any time without affecting the right to future care or treatment.

d. Federal and state law requires healthcare providers to protect the privacy and security of health information. The patient is entitled to all confidentiality protections under applicable federal and state laws. All medical reports resulting from telehealth visits are part of the patient's

medical record. Cloud Health Medical will take steps to ensure health information is protected in accordance with applicable laws.

e. Telehealth may involve electronic communication of the patient's personal health information to other health practitioners who may be located in other areas, including out of state.

f. There is no guarantee that the patient will be treated by a specific Cloud Health Medical provider. The provider reserves the right to deny care for potential misuse of the Services, or for any other reason if, in the professional judgment of the provider, the provision of Services is not medically or ethically appropriate.

Agreement and Consent

I have read and understood the contents of this Consent Form, and I voluntarily consent to receive medical treatment and telehealth services from Cloud Health Medical on behalf of myself or, where applicable, the patient for whom I am the parent or authorized guardian.

Electronic Signature Acknowledgment

By submitting this form online, I acknowledge and agree that:

- My electronic signature constitutes my legal signature and is binding to the same extent as a handwritten signature under applicable law, including the Electronic Signatures in Global and National Commerce Act (E-SIGN) and applicable state electronic signature laws.
- I have had the opportunity to read this Consent in full prior to signing.
- If I am signing as a parent or authorized guardian, I confirm my legal authority to do so and agree to provide documentation of such authority upon request.

Additional State-Specific Consents and Disclosures

The following consents apply to patients accessing Cloud Health Medical Group's services for the purposes of participating in a telehealth consultation, as required by the states listed below. Where a parent or authorized guardian is signing, these disclosures apply on the patient's behalf.

Alaska: I understand that the patient's primary care provider may obtain a copy of records from the telehealth encounter. I have been informed that to register a formal complaint about a provider, I should visit the medical board's website here.

Arizona: I understand the patient is entitled to all existing confidentiality protections pursuant to A.R.S. § 12-2292. All medical reports resulting from telehealth services are part of the patient's medical record as defined in A.R.S. § 12-2291. Dissemination of any images or information identifiable to the patient for research or educational purposes shall not occur without consent, unless authorized by state or federal law.

California: I understand that some or all services may be provided using telehealth technologies. I consent to the sharing of the patient's health information among Cloud Health Medical Group's affiliated entities and care team members for the purpose of coordinating care, consistent with the California Confidentiality of Medical Information Act (CMIA).

Colorado: I consent to the use of telehealth. I understand the patient will not be charged separately for the use of telehealth technology and that privacy will be protected under Colorado law.

Connecticut: I understand that the patient's primary care provider may obtain a copy of records from the telehealth encounter.

Florida: To view the patient's rights under Florida's Patient Bill of Rights and Responsibilities, visit the Florida Agency for Health Care Administration or click here. To view rights under Florida's Weight-Loss Consumer Bill of Rights, click here. I understand the provider may not be physically located in Florida when telehealth services are provided. I consent to receive these services under Florida's Telehealth Practice Act.

Georgia: I have been given clear, appropriate, and accurate instructions on follow-up in the event of needed emergent care related to the telehealth services.

Hawaii: I consent to the use of telehealth as permitted by Hawaii law. I understand that privacy will be protected under state and federal law and that consent may be withdrawn at any time.

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

Illinois: I understand that telehealth may be used for parts of the patient's care. Participation is voluntary, and in-person visits may be chosen when available. I consent to telehealth consistent with Illinois law, including the Telehealth Act (225 ILCS 150).

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

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

Kansas: I understand that if the patient has a primary care provider or other treating physician, the person providing telemedicine services must send a report to such primary care or other treating physician of the treatment and services rendered within three days of consent being provided.

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

Maine: I have been informed that 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 Hampshire: I understand that the patient's primary care provider or treating provider may obtain a copy of records from the telehealth encounter.

New Jersey: I understand the patient has the right to request a copy of their medical information, and that medical information may be forwarded to the patient's primary care provider or healthcare provider of record, or upon request, to other healthcare providers. I have been informed of the provider's identity, credentials, and location, and I consent to receive telehealth services consistent with New Jersey law.

New York: I consent to receive telehealth services. I understand that all communications will be secure and that information will remain confidential under New York law, including New York Public Health Law Article 27-F.

Ohio: I understand that the patient's primary care provider may obtain a copy of records from the telehealth encounter.

Oklahoma: I have been informed that 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.

Oregon: I consent to receive telehealth services under Oregon law.

Rhode Island: If email or text-based technology is used to communicate with the provider, I understand the types of transmissions permitted and the circumstances when alternate forms of communication should be utilized. I have been informed about security measures, such as encryption of data, password-protected screen savers and data files, or other reliable authentication techniques, as well as potential risks to privacy. I have been informed that to register a formal complaint about a provider, I should visit the medical board's website here.

South Carolina: I understand that the patient's medical records may be distributed only with consent and in accordance with applicable laws and regulations to other treating healthcare practitioners.

South Dakota: I have received disclosures regarding telehealth services and their limitations.

Texas: I understand that with consent, medical records related to the patient's services may be sent to the patient's primary care physician within 72 hours after receiving services. I consent to the use of telecommunication technology, including telephone or electronic communications, as part of the patient's care. These services will comply with Texas Medical Board telemedicine standards, and telehealth may be declined at any time.

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: 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 1-800-201-9353. For more information, visit 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 www.tmb.state.tx.us.

Utah: I understand (i) any additional fees charged for telehealth services, if any, and how payment is to be made; (ii) to whom health information may be disclosed and for what purpose; (iii) the patient's rights with respect to health information; and (iv) appropriate uses and limitations of telehealth technology, including emergency health situations. I understand that the telehealth services provided by Cloud Health Medical meet industry security and privacy standards and comply with all applicable Utah regulations. I was warned of potential risks to privacy notwithstanding security measures, and that information may be lost due to technical failures, and agree to hold the provider harmless for such loss. I have been provided with Cloud Health Medical's website and contact information. I am able to: (i) access, supplement, and amend patient-provided personal health information; (ii) obtain upon request an electronic or hard copy of the medical record documenting the telehealth services; and (iii) request a transfer to another provider of the medical record documenting telehealth services.

Virginia: I acknowledge that I have received details on security measures taken with telehealth technology, as well as potential risks to privacy notwithstanding such measures. I agree to hold harmless Cloud Health Medical for information lost due to technical failures and I provide express consent to forward patient-identifiable information to a third party. I consent to the use of telemedicine consistent with Virginia law. I understand that telehealth services will be conducted securely and documented in the patient's record.

Vermont: I understand that the patient has the right to receive a consult with a distant-site provider and will receive one upon request immediately or within a reasonable time after the results of the initial consult. I understand that receiving telemedicine services does not preclude the patient from receiving real-time telemedicine or face-to-face services with the distant

provider at a future date. I have been informed that to register a formal complaint about a provider, I should visit the Vermont Board of Medical Practice website here or the Vermont Board of Osteopathic Examiners here.

Washington: I consent to receive telemedicine services. I understand that all services will meet Washington privacy and security requirements.

Washington D.C.: I consent to receive telehealth services. I understand that the provider may not be located in the District of Columbia at the time of service, and that all telehealth interactions will comply with D.C. telemedicine standards.