Clinical Pediatric Associates
Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

I. CONSENT TO TREAT: I, the patient identified below or the parent or legal guardian of the patient identified below (the "Patient"), consent for the Patient to receive telemedicine services from Clinical Pediatric Associates, including any diagnostic procedures, treatments and/or tests, that the physician(s), a "Provider") determine to be necessary and advisable. I understand that the Patient will be provided with the name, credentials, licensure/certification, and qualifications of the Provider who will be providing the telemedicine services. I understand that, in some instances, such as when the Patient is in school or elsewhere, such telemedicine services may be provided to the Patient without the Patient's parent or legal guardian being present during the consultation.

I understand that telehealth technology will be used to connect the Patient with a Provider, and that such consultations may be conducted by videoconferencing, video images, high quality still images and/or by telephone conference. I consent and authorize Clinical Pediatric Associates to audio record, video record, and/or photograph the consultation as necessary for providing quality healthcare services via telehealth technology. I understand that all or a portion of the recordings, videos or images may become part of the Patient's medical record.

I understand that Clinical Pediatric Associates has implemented security measures sufficient to protect the Patient's electronic health information. Electronic health information is stored in a secure data server in encrypted format to prevent unauthorized individuals from viewing or accessing such data. Clinical Pediatric Associates also utilizes password and authentication protections as additional safeguards where appropriate.

In choosing to participate in a telemedicine consultation, I understand that the use of telemedicine technology for diagnosing or treating health conditions presents certain risks, including but not limited to the following, which may occur in rare instances:

- Transmitted information may be distorted or insufficient to allow for appropriate medical decision making.
- There may be unanticipated delays in diagnoses or treatments due to equipment or technology failures or deficiencies.
- Records of services provided may be lost through technical failures; and in rare cases, security protocols could fail, causing a breach of privacy of personal medical information.

I have been advised and understand all the potential risks, benefits and alternatives to telemedicine and choose to proceed with a telemedicine consultation. I hereby release and hold harmless Clinical Pediatric Associates from any loss of data or information due to technical failures.

In the event of an adverse reaction to treatment or if there is a telemedicine equipment failure, I understand that I may choose to re-initiate telemedicine services through Clinical Pediatric Associates or seek treatment from an urgent care facility or emergency department as appropriate under the circumstances. I also understand that the Provider may terminate the consultation if he or she feels that telemedicine services are inappropriate under the circumstances and may direct the Patient to an in-office visit, emergency department, urgent care provider or specialist as appropriate. I understand that the Provider's responsibility to provide medical services will end upon termination of the telemedicine consultation. I understand that I have the right to terminate the consultation at any time, without affecting the Patient's right to future care or treatment.

I acknowledge that in cases of Patient disclosure of intent to harm self or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may result in accordance with applicable local, state or federal law and/or Clinical Pediatric Associates' policies and practices.

I authorize Clinical Pediatric Associates to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), other applicable law, and by Clinical Pediatric

Associates' Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

I understand that I will have access to the records pertaining to the Patient's telemedicine treatment through the Clinical Pediatric Associates patient portal. I may obtain copies of such records from Clinical Pediatric Associates' patient portal for my own use or to disclose to another provider. Alternatively, I may request a copy of the Patient's records by calling 214-368-3659.

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's health information for purposes of treatment, payment and to facilitate Clinical Pediatric Associates' health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct Clinical Pediatric Associates to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize Clinical Pediatric Associates to release billing information to any healthcare provider involved in the Patient's care.

III. ASSIGNMENT: I hereby assign, transfer and set over to Clinical Pediatric Associates sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that services provided by Clinical Pediatric Associates may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of Clinical Pediatric Associates as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me or the Patient money that is designated to pay for the services provided by Clinical Pediatric Associates, I agree to immediately send the check or an amount equal to the amount received by the insurance plan to Clinical Pediatric Associates. I understand that all bills are to be paid immediately upon receipt. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for the services, that I will be responsible for any reasonable attorney's fees and collection fees incurred by Clinical Pediatric Associates in collecting payment, in addition to the amount of the bill.

V. HIPAA ACKNOWLEDGEMENT: I acknowledge that I have reviewed and understand Clinical Pediatric Associates' Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Clinical Pediatric Associates may update its Notice of Privacy Practices at any time, and that I may receive an updated Notice of Privacy Practices by submitting a request in writing to Clinical Pediatric Associates.

VI. AFFIRMATION: I affirm that I have read and fully understand this Clinical Pediatric Associates Telemedicine Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.