CONSENT FORM

By signing this Member Consent Form, I understand that I am enrolling in Virtare Health™, known as a Virtual Healthcare service provider. The service provider conducts chronic care management, principal care management, transitional care management, mental well-being services, and virtual/in-person healthcare services. This data is shared with the Centers for Medicare and Medicaid Services (CMS), my health insurer and/or my supplemental insurance company.

I give permission for the following services to be performed based on the care plan that is recommended for me. I understand that I may disenroll at any time.

- ☐ **MEMBER CONSENT:** I give permission for the following services to be performed based on the care plan that is recommended for me. I understand that I may disenroll at any time.
- ☐ **RESPONSIBLE PARTY CONSENT:** I give permission for the following services to be performed based on the care plan that is recommended for the member I am enrolling. I understand that I may disenroll the member at any time. On behalf of _____

Yes / No	Service	Description
	Remote Patient Monitoring	Vitals/Biomarker monitoring and support
	Mental Well Being Services	Mental health screening and therapy
	Principle Care Management	Management of 1 chronic condition
	Chronic Care Management	Management of 2 or more chronic conditions
	Virtual/in Person Healthcare Services	Virtual or in-person healthcare visits by a medical provider in support of your existing healthcare team
	Remote Therapeutic Monitoring	Monitoring Medications/Environment

☐ **MEMBER CONSENT** ☐ **RESPONSIBLE PARTY CONSENT**

Member Name (PLEASE PRINT)	Member Date of Birth
Responsible Party Name	**Relationship to Member**
Signature	**Date**
Email	**Phone**

NOTE: Members and/or their family caregivers are advised to immediately contact 911 for any medical emergencies

Financial Responsibility Acknowledgement

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

I authorize Virtare Health™ to bill my insurance for appropriate coverage and authorize payment to be made directly to the Service Provider. An attempt to bill Medicare and/or supplemental insurance, if applicable, will be made by the Service Provider on my behalf for the healthcare services mentioned above and any additional medical care and treatment through applicable Current Procedural Terminology (CPT) codes. I understand that I may disenroll at any time.

Please be advised, that should your insurance not cover all billed services and/or equipment provided by the Service Provider, you will be notified and have the option to decide whether or not to continue on a Fee For Service (Private Pay) basis or disenroll from the program. We will make an effort to collect on copayments, deductibles, and any non-covered services that were utilized. Standard deductible rates will apply.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider for the services to be provided.
- It is your responsibility to know your insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process

generally takes 45-60 days from the time the claim is received by the insurance company.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.
- In the event that I opt out of participation due to noncompliance with daily vital management, I understand I will be responsible for returning all equipment at my own expense to:

  _____

  RE: Equipment Return

  _____

  _____

I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Name	Signature	Date

Data Sharing and Release Agreement

I understand that Virtare Health™ complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and no medical information will ever be released without the member's consent. I understand that I may revoke this consent by written request, at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. I also understand that I have the right to restrict the disclosure of specific information in my medical record if I request such restriction in writing. I also understand that my request may be denied, if such information is required for Health Care Operations – which include, but are not limited to, provider review functions, claims processing and payment, and quality assessment. This consent is in response to federal laws that require consent for insurance processing.

Restrictions	

☐ **MEMBER CONSENT:** I authorize consent to the release of my past medical records.

☐ **RESPONSIBLE PARTY CONSENT:** I authorize the consent to the release of the enrolled member's past medical records.

Name	**Signature**	**Date**

Data Sharing and Release Agreement Continued

☐ **MEMBER CONSENT:** I authorize the service provider to use my de-identified information in a limited data set including the following identifiers: Dates, such as admission, discharge, service, and date of birth (DOB), City, state, and zip code (not street address), Age, Any other unique code or identifier that is not listed as a direct identifier. I understand a limited data set may be disclosed to an outside party without a patient's authorization only if the purpose of the disclosure is for research, public health, or health care operations purposes and the person or entity receiving the information signs a data use agreement (DUA) with the covered entity or its business associate.

☐ **RESPONSIBLE PARTY CONSENT:** I authorize the service provider to use the enrolled member's de-identified information in a limited data set including the following identifiers: Dates, such as admission, discharge, service, and date of birth (DOB), City, state, and zip code (not street address), Age, Any other unique code or identifier that is not listed as a direct identifier. I understand a limited data set may be disclosed to an outside party without a patient or responsible party's authorization only if the purpose of the disclosure is for research, public health, or health care operations purposes and the person or entity receiving the information signs a data use agreement (DUA) with the covered entity or its business associate.

Name	Signature	Date

Data Sharing and Release Agreement Continued

- ☐ **MEMBER CONSENT:** I allow the Service Provider to communicate with my Physicians, Emergency Contacts, and Individuals listed below to request any relevant medical information on my behalf. This includes sharing my data with my Physician, if medically necessary.
- ☐ **RESPONSIBLE PARTY CONSENT:** I allow the Service Provider to communicate with the enrolled member's Physicians, Emergency Contacts, and Individuals listed below to request any relevant medical information. This includes sharing data with the enrolled member's Physician, if medically necessary.

Name	Signature	Date

Contact	Relationship	Phone/Fax/Email