

General Consent for Care and Treatment Consent

Consent to Treat and Patient's Rights

As a patient seeking care, I authorize Theoria Medical PLLC ("Theoria") providers to perform reasonable and necessary medical examinations, testing and treatment.

I understand that I have the right to be informed about my condition and the recommended surgical, medical or diagnostic procedure to be used, along with the possible risks involved, so that I may make the decision whether to undergo any suggested treatment or procedure. I have the right to know who is responsible for authorizing and performing any treatments and procedures. I understand that I will not be subjected to any procedure without my voluntary, competent and knowledgeable consent or the consent of my legally authorized representative. Where medically significant alternatives for care or treatment exist, I will be provided this information. I also understand and expressly consent to the use of medical transcription software to record and transcribe patient notes during my appointments and encounters with Theoria providers.

Consent to Release Information

I acknowledge that Theoria may release protected health information as necessary for treatment, payment and health care operations. I understand that use or disclosure of my protected health information may be necessary before my insurer will pay the cost of my medical treatment. I acknowledge and consent to allow Theoria to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to: treatments, prescriptions, labs, medical and prescription history and other protected health information.

Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Theoria all rights and interests in payments from third-party payors, including but not limited to health plans, health insurers, Personal Injury Protection (PIP), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Theoria is unable to collect from my third-party payor, to the extent allowable by law. Where Theoria is an out-of-network provider, Theoria will provide me with the requisite notice of such and seek my consent for any unpaid amounts prior to treatment and billing for said treatment. I understand I have the right to contest any out-of-network costs that have not been approved by me to the extent that those costs are higher than my in-network costs are for the same procedure or treatment.

Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such

programs is correct. I authorize any holder of medical information about me to be released to Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Theoria on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

Lab / X-ray / Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray or diagnostic services that are not provided by Theoria or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer, to the extent allowable by law.

Consent to Communications

I grant Theoria permission to use or disclose my name, e-mail address, cellular phone number and/or other telephone number(s) provided to Theoria, at this time or at a later time, in order to receive communications by e-mail, text message and/or telephone call by Theoria and its affiliates, clinical providers and business associates, along with any billing services, collection agencies, agents or other third parties who may act on its behalf. Such e-mails, text messages and/or telephone calls may be related to any purpose, including those purposes related to my financial account and/or the healthcare services rendered. I understand this consent to communications is not required to receive healthcare services from Theoria or any services of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to communications at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name

Patient Date of Birth

Patient/Personal Representative Signature

Signature Date

Personal Representative Name (if applicable)

Wound Care Patient Consent Form

I understand and hereby voluntarily consent and authorize Theoria Medical PLLC (“Theoria”), by and through its practitioners and their designees, to provide wound care treatment during my stay at _____.

I understand that this Consent form will be valid and remain in effect from the date of signature as long as I (the patient) receive care and treatment from Theoria. I understand that a new consent form may be obtained when I am/a patient is discharged from this Facility/Center.

- 1. General Description of Wound Care Treatment:** I/Patient acknowledges and it has been explained to me/the Patient that wound care treatment may include but shall not be limited to: Debridements (the removal of unhealthy or dead tissue from the wound to promote healing), dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, compression therapy (sustained graduated compression with the use of multi-layer compression bandaging that will be wrapped typically from toes/foot to just below the knee), use of skin substitutes to treat acute and chronic non-healing wounds and soft-tissue grafting, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays and other imaging studies and administration of medications as prescribed and directed by a licensed clinician.
- 2. Benefits of Wound Care Treatment:** The benefits of treatment include: enhanced wound healing and reduced risks of amputation and infection.
- 3. Risks/Side Effects of Wound Care Treatment:** The risks/side effects of wound care treatment may include, but are not limited to: Infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to topical and injected local anesthetics or skip prep solutions, removal of healthy tissue, prolonged healing or failure to heal.
- 4. Likelihood of achieving goals:** Patients who follow a trained clinician’s plan of care are more likely to have a better health outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications and injuries from both known and unforeseen causes, and no warranty or guarantee is made for any result or cure.
- 5. Alternative to Wound Care Treatment:** I understand that I/the patient may refuse wound care treatment altogether, although the risks and side effects of doing so should be carefully considered. I may instead continue a course of conservative treatment or forego any wound care treatment. I also have the option of refusing any particular procedure prior to its performance.

I hereby authorize Theoria to undertake appropriate wound service and care. Furthermore, I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of such procedure.

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I hereby authorize Theoria and/or their designees or agents to dispose of any specimen or tissue taken from my body.

I have been made aware of certain risks and consequences that are associated with the treatments and procedures described above and willingly consent to these treatments as recommended by medical professionals.

Patient Name

Patient Date of Birth

Patient/Personal Representative Signature

Signature Date

Personal Representative Name (if applicable)

Telemedicine Patient Consent Form

Telehealth involves the use of secure electronic communications, information technology or other means to enable a healthcare provider at one location and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing and/or referring the patient to in-person care, as determined clinically appropriate. 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 Theoria Medical PLLC or Theoria Medical PCP (“Theoria”) and Theoria’s engaged medical providers may include patient consultation, diagnosis, treatment recommendations, examinations and/or referral to in-person care as determined clinically appropriate, and may involve video and audio communication technologies and other digital health tools. Additionally, Theoria may use private and secure medical software to record and transcribe patient examinations and ensure clinically-accurate medical records.

Electronic Transmissions: The types of electronic transmission that may occur using the telehealth/telemedicine platform include:

- appointment scheduling
- completion of medical intake forms
- exchange and review of patient intake forms, health records, images, diagnostic and/or lab results
- two-way interactive technology communications between you and your provider
- delivery of a consultation report
- prescription refill reminders
- and other electronic transmissions for the purposes of rendering clinical care to you.

Expected Benefits: By utilizing Theoria’s telehealth platforms, it is anticipated that you will experience improved access to medical care by enabling providers to treat and see you even when you or the provider are not in the same physical location. You will have convenient access to follow-up care and will be able to see providers in a more timely manner than may otherwise be possible.

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 medical provider will make that determination. Our providers are in 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. If you do not, we strongly encourage you to locate one. Theoria offers primary care services that may be appropriate for you, however you are under no obligation to utilize Theoria as your primary care provider.

Risks: In using telehealth technology, there is a risk, though unlikely, of data being intercepted by persons other than the treating medical provider. There is also a risk of technical failure during the telehealth visit that is beyond the control of Theoria Medical. Delays in evaluation and treatment could occur due to deficiencies or failures in the equipment and technology. The quality of the data transmitted could affect the services provided. In rare events, your provider may determine that the transmitted information is of inadequate quality and therefore may need to reschedule a telehealth consult or an in-person visit. In rare circumstances, a lack of access to complete medical records could result in adverse drug interactions or other clinical judgment errors.

Patient Acknowledgments / Consents:

- I understand that if I am experiencing a medical emergency, I should call 9-1-1 immediately and my medical provider cannot connect me directly with any emergency services.
- I may elect to seek in-person services as an alternative to receiving telehealth services.
- I understand and expressly consent to the use of medical transcription software to record and transcribe patient notes during my appointments and encounters with Theoria providers.
- I have the right to withhold or withdraw my consent to use telehealth during the course of my care at any time without affecting my right to future care or treatment.
- Federal and state law requires healthcare providers to protect the privacy and security of my 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.
- Theoria will take steps to ensure that my health information is not accessed by anyone who is not authorized to access it by law or by express patient consent. Telehealth may involve the communication of my personal health information to other health care practitioners who may be in other areas, including out of state.
- I understand that some services involving tests may be conducted at another location or another time (such as testing of bloodwork) at the direction of my medical provider.
- I understand that persons may be present during the telehealth visit other than my provider in order to operate the telehealth technologies.
- I understand and expressly consent to the use of medical transcription software to record and transcribe patient notes during my appointments and encounters with Theoria providers.
- I have the right to request a copy of my medical records, and I understand upon my affirmative

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consent my medical records will be forwarded directly to myself or my designee.

phone: 833-578-2763
www.theoriamedical.com

I authorize the electronic transmission of my medical information and videoconference sessions for the sole purpose of being assessed and treated by a medical provider to further my medical care. I acknowledge that although very unlikely, there is a possibility of the data being intercepted by persons other than the caring medical provider. I understand there also is a risk of technical failures during the telehealth visit beyond the control of Theoria. I agree to hold harmless Theoria and my Theoria provider for delays in evaluation or for information lost due to such technical failures.

I understand that I can withdraw my consent to be seen via telemedicine or data sharing at any time during my stay at my current rehabilitation facility. In the event that I choose not to participate in a telemedicine session, no adverse action will be taken against me nor will it cause any delay in my care.

Patient Name

Patient Date of Birth

Patient/Personal Representative Signature

Signature Date

Personal Representative Name (if applicable)

Remote Patient Monitoring Consent Form

Theoria Medical is a comprehensive medical group and technology company dedicated to serving patients across the care continuum with an emphasis on post-acute care and primary care. Theoria serves facilities across the United States with a multitude of services to improve the quality of care delivered, refine facility processes, and enhance critical relationships. We offer a broad scope of services including multispecialty physician services, telemedicine, remote patient monitoring, and more. We currently operate primary care clinics and provide medical services to skilled nursing facilities in numerous states across the nation.

As a patient with a chronic health condition, you may benefit from a continuous monitoring program that Theoria offers. Remote patient monitoring (RPM) provides around-the-clock care for patients with chronic conditions through proactive and non-invasive monitoring of one's vital signs to facilitate early intervention if necessary.

Services Provided: Theoria's RPM services may include the use of devices to monitor certain patient vitals, such as heart rate, blood pressure, glucose levels, and more.

Expected Benefits: By utilizing Theoria's RPM services, it is anticipated that you will experience improved access to medical care by enabling providers to treat and see you even when you or the provider are not in the same physical location. You will have convenient access to follow-up care and will be able to see providers in a timelier manner than may otherwise be possible.

Limitations: The primary difference between RPM 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 medical provider will make that determination. Responsibility for your overall medical care should remain with your local primary care provider, if you have one. If you do not, we strongly encourage you to locate one. Theoria offers primary care services that may be appropriate for you, however you are under no obligation to utilize Theoria as your primary care provider.

Risks: In using RPM technology, there is a risk, though unlikely, of data being intercepted by persons other than the treating medical provider. There is also a risk of technical failure of an RPM device that is beyond the control of Theoria Medical. Delays in evaluation and treatment could occur due to deficiencies or failures in the equipment and technology. The quality of the data transmitted could affect the services provided. In rare events, your provider may determine that the transmitted information is of inadequate quality and therefore may need to reschedule a telehealth consult or an in-person visit. In rare circumstances, a lack of access to complete medical records could result in adverse drug interactions or other clinical judgment errors.

Patient Acknowledgments / Consents:

- I understand that if I am experiencing a medical emergency, I should call 9-1-1 immediately and my medical provider cannot connect me directly with any emergency services.
- I may elect to seek in-person services as an alternative to receiving RPM services.
- I have the right to withhold or withdraw my consent to use RPM services during the course of my care at

any time without affecting my right to future care or treatment.

- I authorize the electronic transmission of my medical information for the purpose of being assessed and treated by a medical provider to further my medical care. I acknowledge that although very unlikely, there is a possibility of the data being intercepted by persons other than the caring medical provider. I understand there also is a risk of technical failures during the use of RPM services that are beyond the control of Theoria. I agree to hold harmless Theoria and my Theoria provider for delays in evaluation or for information lost due to such technical failures.
- I understand that I can withdraw my consent to be monitored via RPM technology or data sharing at any time during my stay at my current facility. In the event that I choose not to participate in the use of RPM services, no adverse action will be taken against me nor will it cause any delay in my care.

Patient Name

Patient Date of Birth

Patient/Personal Representative Signature

Signature Date

Personal Representative Name (if applicable)