

Patient Consent and Participation Agreement

This Patient Consent and Participation Agreement ("Agreement") entered into as of the Effective Date below, outlines the terms for patient participation in the CPESN USA Network and JoinCareTeam PC's EquityRx Program. By signing this Agreement, the patient consents to enroll in the Program and agrees to the responsibilities below, designed to ensure transparency, protect rights, and promote successful outcomes.

1. Program Overview

Purpose Statement: The Remote Therapeutic Monitoring (RTM) program is designed to improve patient health outcomes through consistent monitoring and medication adherence, enhanced by regular communication with healthcare providers throughout the program.

Eligibility Requirements: Patients must be enrolled in Medicare, Medicaid, or other qualified insurance programs, have a chronic condition requiring monitoring (e.g., cardiovascular, diabetes), and maintain RTM equipment in good condition. This program supports patients in managing chronic conditions while ensuring better access to healthcare resources.

2. Participation Terms

Cancellation: Participation can be canceled at any time by notifying the local pharmacy or program coordinator.

Information Sharing: Relevant medical information, including medication history, treatment details, and diagnosis codes, will be shared through our electronic medical record (EMR) system to coordinate care, ensure accurate treatment, and meet legal and billing requirements, in compliance with HIPAA. This supports timely and informed decision-making by healthcare providers, ensuring better care for patients. This ensures that all necessary parties have access to accurate and timely information for your care.

Single Provider Participation: Patients may only participate in RTM with one provider at a time.

3. Privacy Notice

HIPAA Compliance & Data Protection: We strictly adhere to HIPAA regulations to ensure your personal health information (PHI) remains secure. Devices used in this program do not access personal information beyond required health measurements. You have the right to request restrictions on how we use or disclose your PHI for treatment, payment, or healthcare operations, though we may not always be able to agree to your request. You also have the right to request confidential communications through alternative means or at alternative locations, such as using an alternate phone number or email address. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or the U.S. Department of Health and Human Services without fear of retaliation.

Data Retention Policy: Patient data will be retained for the duration of the program and for a period of ten years thereafter, in compliance with applicable laws.

Third-Party Involvement: In some cases, data may be shared with trusted third-party vendors (e.g., equipment manufacturers) for maintenance or service purposes. All data-sharing agreements are governed by HIPAA.

Patient Rights: Patients may request restrictions on PHI use or disclosure for treatment, payment, or healthcare operations. They may also request corrections, confidential communications, and file complaints with the Privacy Officer for violations emailing privacy@joincareteam.com or by calling 1-888-488-0621.

A copy of the Patient Privacy Policy may be obtained at <https://joincareteam.com/privacy-policy/>. A paper copy will be provided upon request.

4. Copays and Insurance

Copays: Some beneficiaries may have copays, as determined by their insurance provider.

Secondary Insurance: Supplemental or secondary insurance may assist with RTM-related costs.

Cash Pay Option: Patients choosing to enroll on a cash basis could be charged a maximum out of pocket including a one-time \$50 equipment fee and a recurring monthly fee of up to \$200.

Questions: For any questions about copays or coverage, contact 1-888-488-0621 or email: support@joincareteam.com.

5. Communication Expectations

Responsiveness: Regular communication is essential. Patients must respond to outreach promptly.

Follow-Up Contact: Patients agree to receive communication via phone or text for program-related updates, including medication reminders or troubleshooting device issues.

Monthly Check-Ins: Patients can expect monthly contact to discuss progress.

Device Monitoring: If a patient's device fails to send readings, troubleshooting contact may occur.

Emergency Response: This program does not provide 24-hour emergency services. Patients must follow their healthcare provider's recommended emergency plan.

6. Equipment Usage

Exclusive Use: Devices must not be shared to maintain accurate readings.

Device Issues: Patients must notify the pharmacy immediately if issues occur.

Tampering: Patients must not tamper with or attempt to repair devices. Intentional tampering may result in fees.

Device Ownership: Terms apply while the patient possesses RTM equipment.

7. Support and Resources

Technical Support: Contact your local pharmacy for technical assistance.

Insurance Coverage: Patients will receive a detailed breakdown of potential costs prior to enrollment.

8. Feedback Mechanisms

Feedback Collection: Patients are encouraged to share feedback through surveys or direct communication with the pharmacy.

Program Improvements: Feedback will help improve the program and ensure high-quality care.

Service Improvements and Recommendations:

Patient feedback and program data may be reviewed by JoinCareTeam to identify opportunities for enhancing services or recommending additional programs that align with patient care needs.

9. Payment Authorization (Release of Billing Information and Assignment of Benefits)

Authorization of Payment: Patient's signature below confirms request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to JoinCareTeam Pharmacy for any medical supplies and/or services furnished to me by JoinCareTeam. I authorize any holder of medical information about me to release to them my physician(s), caregiver, CMS, its agents

and to my primary and/or other medical insurer or provider any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible. Detailed billing information is available upon request to ensure transparency. Patients are responsible for any costs not covered by insurance, including copayments, coinsurance, and charges for non-covered services, such as medication management. **Information Release:** Relevant medical information, including medication history, diagnosis codes, and treatment summaries, will be shared through our electronic medical record (EMR) system to coordinate care, facilitate eligibility, and ensure compliance with legal and billing requirements, minimizing redundancy across sections.

Secondary Insurance: Patients authorize billing of secondary insurance but acknowledge they are responsible for any remaining balance.

Revocation: This authorization remains valid unless revoked in writing by the patient. Revocation will not apply to claims already submitted or processed prior to the receipt of the written revocation.

10. Patient Rights and Responsibilities

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care, may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. Patients must notify their local pharmacy within 48 hours of any equipment malfunctions, failures, damage, loss, or theft and take steps to safeguard the equipment to prevent such issues. They are responsible for safeguarding the equipment and ensuring its proper use.

2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify the dispensing pharmacy in such cases.
3. The patient should promptly notify the Dispensing pharmacy of any changes to their address or telephone.
4. The patient should promptly notify the Dispensing pharmacy of any changes concerning their physician.
5. The patient should notify the dispensing pharmacy of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any charges which the patient's insurance company does not pay.

Access to Records: Patients can request access to their monitoring data and health records at any time by contacting 1-888-488-0621 or support@joincareteam.com.

Withdrawal from Program: Patients may withdraw from the program by providing written or verbal notice to their local pharmacy or contacting 1-888-488-0621 or support@joincareteam.com.

Education: The patient acknowledges receipt of the RTM device and confirms they have received education on its setup, functionality, data transmission, adherence tracking, and troubleshooting. The patient understands the importance of consistent use, agrees to follow prescribed guidelines, and knows how to seek support if needed. This acknowledgment ensures full understanding of the program expectations and requirements.

11. Consent

By signing this document, the patient confirms agreement to all outlined terms, including the Privacy Notice, Billing Information Release, and Assignment of Benefits, acknowledges receipt and review of these notices, and consents to receiving communication via text and phone for program purposes. Patients may withdraw consent for specific communication methods, including text messages, by notifying the local pharmacy or contacting 1-888-488-0621 or support@joincareteam.com.

Patient Consent

Patient Name (Printed)	
Patient Signature:	
Date Signed ("Effective Date"):	
Patient Date of Birth:	
Patient Representative Signature:	
Patient Representative Relation to Patient:	