

ChatRx Telemedicine Consent Form

Patient Information: Populated electronically with the information below

- **Name:** [auto-populated]
- **Email Address:** [auto-populated]

Provider Information:

- **Provider Name:** [Tod Stillson MD]
- **Provider Contact Information:** clinical@chatrx.md

Purpose of Telehealth Visit:

The purpose of this telehealth visit is to provide healthcare services remotely using electronic communications. This includes an assessment to qualify for online medical treatment with our medical device product using chat-based electronic means without audio or visual interaction with the healthcare provider.

Acknowledgment and Consent:

1. **Use of Artificial Intelligence:**

- I understand that my assessment is being directed by an Artificial Intelligence chat agent that has been trained by ChatMD to evaluate me for a ChatRx qualified medical condition.
- I acknowledge that while the AI agent has been trained to provide accurate evaluations, it may have limitations and is not a substitute for professional medical judgment.

2. **Purpose of Treatment:**

- I understand that the purpose of treatment is to provide healthcare services remotely using electronic communications through ChatRx.

3. **Nature of Services:**

- I understand that the services provided include, but are not limited to, medical electronic assessment, diagnosis, and treatment of qualified medical conditions using the ChatMD medical device, and do not involve a face-to-face encounter, video encounter, audio encounter, or physical exam.
- I acknowledge that the ChatMD device is not designed to evaluate and treat conditions necessitating a physical examination, nor is it intended to address conditions beyond those specifically qualified for treatment with ChatMD.
- I consent to the electronic transmission of prescription treatment, work-school notes, and educational materials related to medical encounters using the ChatMD device.

4. Provider-Patient Relationship:

- I acknowledge that a provider-patient relationship will be established with the healthcare provider(s) delivering services through ChatRx.

5. Confidentiality:

- I understand that ChatRx & ChatMD complies with HIPAA regulations and takes measures to ensure the privacy and security of my health information.
- I acknowledge that my health information may be shared with other healthcare professionals involved in my care as necessary.

6. Payment Terms:

- I understand and agree that ChatRx operates on a cash-only basis and does not accept insurance or interface with third-party medical payment providers.
- I acknowledge that I am responsible for full payment of fees incurred with the use of the ChatMD device at the time services are rendered.

7. Compliance with Agreement

- I acknowledge that compliance with the terms of this agreement is essential for maintaining the provider-patient relationship established through ChatRx. I understand that failure to adhere to the terms outlined in this agreement may result in the termination of the email relationship with my healthcare provider. This includes but is not limited to, inappropriate use of the ChatRx system, non-compliance with treatment recommendations, or other violations of the agreement terms

8. Hold Harmless for Technical Failures

- I understand that while every effort is made to ensure the reliability and security of the ChatRx & ChatMD system, there may be instances of technical failures that could result in the loss of information. I agree to hold ChatRx and ChatMD, its healthcare providers, and affiliated entities harmless for any loss of information due to such technical failures. This includes, but is not limited to, data corruption, system outages, network issues, and other unforeseen technical issues.

9. Emergency Situations:

- I understand that telehealth services provided by ChatRx are not suitable for emergency situations. In case of an emergency, I will contact emergency services or go to the nearest emergency room.
- I understand the physician-patient e-mail is not to be used in emergency situations

Patient Consent:

I have read and understand the information provided above regarding treatment services provided by ChatRx. I hereby give my informed consent to receive healthcare services through ChatRx

2-19-25

Electronic signature-