2-19-25

ChatRx Consent to Treat Form

Patient Information:

- **Name:** {First and Last Name]
- **Date of Birth:** [mo/date/year]
- **Address:** [including zip code]
- **Phone Number:** [(xxx)-xxx-xxxx]
- **Email Address:** [auto-populate from account creation]

Provider Information:

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

Nature of Services:

I, the undersigned patient, hereby consent to receive healthcare services from ChatRx. These services may include diagnosis, treatment, and related services provided via a telemedicine platform.

Consent and Acknowledgment:

By signing this form, I acknowledge and agree to the following:

1. **Purpose of Treatment:**
    - I understand that the purpose of treatment is to provide healthcare services remotely using electronic communications through ChatRx.
2. **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 ChatRx.
    - I consent to the electronic transmission of prescription treatment, work-school notes, and educational materials related to medical encounters using the ChatMD device.
3. **Provider-Patient Relationship:**
    - I acknowledge that a provider-patient relationship will be established with the healthcare provider(s) delivering services through ChatRx. This relationship is

only for acute medical conditions that qualify for treatment with ChatRx telemedicine and do not extend beyond those rigid boundaries. The relationship does not replace your need for an in-person medical provider.

4. **Confidentiality:**

    - I understand that ChatRx and ChatMD comply 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.

5. **Use of Artificial Intelligence:**

    - I understand that my assessment and treatment in the ChatMD medical device 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 has been trained to provide accurate evaluations, it may have limitations and is not a substitute for professional medical judgment from a medical provider.

6. **Fees-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. **Emergency Situations:**

    - I understand that telemedicine 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.

Electronic check box consent