Consent and Statement of Financial Responsibility

Telemedicine Services

I, the person signing below as Patient or Responsible Party, consent to have The Kroger Co. ("Kroger"), and its affiliates and subsidiaries' healthcare practitioner(s) ("Healthcare Practitioners") treat me, or the Patient for whom I am responsible, using telemedicine services. Telemedicine includes the practice of healthcare delivery, diagnosis, consultation, treatment, and education, using electronic communication. Benefits include but are not limited to: (1) I may not have to travel to a clinic location by utilizing telemedicine services; (2) care, treatment, or services may be more efficient and timely, and (3) cost for treatment may be reduced. Potential risks include, but are not be limited to: (1) a possibility exists that communications or security could fail or (2) I may have to go to a clinic location if it is felt that the information obtained via telemedicine is not sufficient to treat or diagnosis. The electronic communications used for our telemedicine services includes security protocols and safeguards to protect the confidentiality and integrity of Patient information and images.

I, on behalf of myself, or on behalf of the Patient for whom I am responsible, consent to receive Patient care that may include (1) histories and questionnaires; (2) visual and physical assessment examinations; (3) diagnostic screening or testing; (4) treatment, wellness care, disease management, and counseling; and, (5) if necessary, prescription, administration or application of prescription medication, using video and audio technology to communicate with the Healthcare Practitioner. I consent and acknowledge that for all purposes that by signing below, I am the legally responsible party and that I am consenting to healthcare treatment for myself or consenting on behalf of a minor or other person, and that I verify that I am the parent, legal guardian, or personal representative of that person.

I have been informed about the limited services provided and that treatment will be performed by a Healthcare Practitioner who is a Nurse Practitioner, Physician Assistant, or Pharmacist, as permitted, and for nutrition counseling, services will be provided by a Dietitian. I understand that Healthcare Practitioner(s) will only assess my medical condition, or the medical condition of the Patient for whom I am responsible, for a limited scope and number of health conditions, treatments, managements, and prescriptions. Any treatment will be in accordance with the Healthcare Practitioner's assessment, the result of any test(s) or screening(s) performed, nationally accepted best practices and clinical guidelines, any collaborative protocol(s), the licensure of the Healthcare Practitioner, and in accordance with all applicable law and regulations.

I acknowledge and agree that any test results may be sent to the address on my account as the Patient, or as the responsible party, and to my regular professional healthcare provider(s). A copy of my treatment documentation may be sent to any of my healthcare providers. The Healthcare Practitioner may contact my healthcare provider(s) to obtain medical information and discuss aspects of my treatment and progress in controlling my health condition and/or for a recommendation for further evaluation. Any other specific medical questions I have about my, or the Patient's health condition, treatment, or care should be discussed with the Patient's regular healthcare provider(s). All existing safeguards and laws regarding Patient access to, and Kroger's use of, the Patient's medical information applies to these telemedicine services. Any Patient images or information from the telemedicine services will only be used to facilitate diagnosis, treatment, or payment.

I acknowledge and understand that I am not required to purchase any recommended or prescribed items, products, or services from the pharmacy, the host retail location, and/or Kroger. I also acknowledge and understand that I may decline telemedicine services and visit a traditional medical clinic or other provider of my choice. I understand that my consent to the telemedicine service may be withheld or withdrawn at any time before or during the consultation, without affecting my right to future care, treatment, and services.

I hereby assign and transfer all my (or the Patient for whom I am responsible) rights, entitlement, and interest in all benefits and payments now due and payable, or that become due and payable, under any insurance policies, any replacement policies, any self-insurance program, workers' compensation plan, employers and state welfare funds, or under any other benefit or entitlement plan for the care given me by Kroger. In addition, I authorize the release of any protected health information deemed necessary by Kroger or its agents or divisions to my insurance carrier or any entitlement program provider to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking this authorization.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including federal healthcare beneficiaries except prohibited balance billing and, delinquent accounts shall bear interest at the legal rate allowed. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect any outstanding balances on my or the Patient's account. If Kroger has an agreement with my health plan or insurer, I understand that I am responsible for paying any co-payment or deductible amount today. I understand that I may be billed for any additional deductible, co-insurance, or non-covered services deemed my responsibility by my insurance carrier or entitlement plan.

I recognize the information gathered by Kroger may need to be disclosed to a third party for purposes of administration, treatment, payment, and other healthcare operations as outlined in the Notice Of Privacy Practices. I consent to such release. I confirm that I have read, or have had read to me, this form. I have had all questions related to this form answered and understand it.

Failure to modify or cancel an appointment before the scheduled appointment time may incur a "no-show" fee.*

If I, or the patient for whom I am the responsible party for, is a **federal** beneficiary (example: Medicaid, Medicare, TRICARE, Railroad, etc.) I have notified Kroger and provided evidence of coverage.

Patient Name (Please print) _____ Date of Birth _____

Signature of Patient (OR, if other than Patient, signature of responsible party):

_____Today's Date_____

Patient's Relationship to Responsible Party_____Date of Birth_____Telephone #_____-_____-_____

*Medicaid recipients are excluded from the $20 "no-show" fee.

**********INTERNAL USE ONLY**********

TELEPHONE CONSENT: _____/_____ _____/_____ -_____-_____

Date Time Consent given by (Name / Patient's Relationship to Responsible Party)/ Telephone #

☐ Obtained by Associate (where permitted by state law), check at least two Patient identifiers: ☐ Name ☐ DOB ☐ Address

☐ Attempted, Unsuccessful

Associate name (print):_____ Title:_____ Signature_____