PATIENT INTAKE PACKET

Last Modified: July 7, 2026

Castlight Health, Inc., including its affiliates and subsidiaries (collectively, "**Castlight**") and Vera Whole Health, Inc., including its affiliates and subsidiaries, as well as the Vera-friendly PCs, (collectively, "**Vera**") ("**it**," "**our**," "**us**," or "**we**") refers to the two (2) national healthcare delivery organizations providing digital healthcare navigation and clinical and advanced primary care services.

The following forms, agreements, and notices collectively reviewed together creates the "**Patient Intake Packet**" or "**forms**" and are applicable to the above-mentioned companies. These forms are specific to your use of Castlight's "**Castlight Platform,**" and Vera's "**My Vera App**" and the Vera-branded advanced primary care clinics, where clinical services are accessible in its various care center state locations, which are defined as the suite of company offerings (collectively "**Services**").

Once signed by you or your authorized representative, this Patient Intake Packet governs our relationship with you. We may update these forms to provide greater transparency and understanding on how your Personal Information may be collected, used, and disclosed to provide our Services to you.

This Patient Intake Packet consists of the following forms:

1. NOTICE OF PRIVACY PRACTICES
2. PATIENT RIGHTS AND RESPONSIBILITIES
3. AUTHORIZATION TO RECEIVE SERVICES
4. AUTHORIZATION TO AUDIO RECORD SERVICES
5. AUTHORIZATION TO RELEASE PHI
6. FINANCIAL RESPONSIBILITY AGREEMENT
7. PATIENT MESSAGING AUTHORIZATION
8. NOTICE OF NON-DISCRIMINATION
9. HOW DID YOU HEAR ABOUT US?
10. SPECIAL NOTICES UNDER ACA

**If updated, we will include the date of the most current version in the upper left corner of the first page of this Patient Intake Packet.

Please read the following pages carefully before signing each individual form.

NOTICE OF PRIVACY PRACTICES

Last Modified: July 7, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect the privacy of our members ("**consumer**," "**individual**," "**patient,**" "**user,**" or "**you**").

This Notice of Privacy Practices ("**NPP**" or "**Notice**") describes how your medical information, referred herein as protected health information ("**PHI**") may be used and disclosed, our obligations to protect your PHI, your privacy rights in accessing such information, and how you may contact us.

We understand that your PHI is very sensitive. The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") protects the PHI we obtain and create in providing care and services to you. Your PHI may include the medical information we receive from you or your providers such as your symptoms, test results, diagnoses, treatment, health notes, and billing and payment information relating to these services.

In general, we will only use or disclose your PHI as described in this Notice in relation to your healthcare treatments, payments, and/or our operations, or as required by law - in these cases we do not need your authorization. If we believe any additional use or disclosure of your PHI is necessary that goes beyond these use cases, we will not use or disclose your PHI without your authorization.

HOW WE MAY USE AND DISCLOSE YOUR PHI

Under HIPAA, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your PHI. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

We may use and disclose your PHI in the following ways, but are not limited to:

1. **For Treatment:** We may use or disclose your PHI to provide you with medical treatment or services. For example, Personal Information obtained by a nurse, physician, or other member of our health care team may be recorded in your medical record and used by members of our health care team to help decide what care may be right for you. We may also provide or exchange information with other health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

2. **For Payment:** We may use and disclose your PHI so that treatment and services you receive at our clinics or with our associated providers may be billed to you and payment collected from you, your insurance company, or other third party. For example, health plans may request information from us about your medical care. Any information we provide to health plans about you may include your diagnoses, procedures performed, or recommended care.

3. **For Health Care Operations:** We may use and disclose your PHI for our business operations, such as assessing the quality of and improving our services to the extent permitted by applicable law. For example:

    a. We may use and disclose your PHI to review the qualifications and performance of our health care providers and to train our staff, including to maintain the safety and security of our facilities.
    b. We may use and disclose your PHI to conduct or arrange for services, including:
    c. Medical quality review by your health plan;
    d. Audit functions, including fraud and abuse detection and compliance programs;
    e. Statements about certain uses and disclosures;
    f. We may contact you to remind you about appointments;
    g. We may use and disclose your PHI to give you information about treatment alternatives or other health-related benefits and services; and
    h. We may contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

4. **As Required by Law:** We must make any disclosure required by state, federal, or local law.

5. **To Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.

6. **To Notify Family Members and/or Authorized Individuals:** Unless you object, we may release your PHI to a family member or individual you authorize, who may be involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or authorized individual your condition and that you are in a hospital.

7. **Electronic Sharing and Pooling of Your Information:** We may take part in or make possible the electronic sharing or pooling of your PHI through participation in a health information exchange ("**HIE**") or an equivalent electronic platform for the sharing or pooling of PHI. If you need medical treatment from another participating healthcare provider, HIEs allow the other provider to electronically gather relevant medical information from our records. If you have received care from another participating healthcare provider, HIEs allow us to electronically gather the relevant portions of your medical information or PHI from their records. This improves your overall quality of care by reducing delays and by helping to ensure that the providers involved in your care have the most current healthcare information available to them. You may elect to opt-out, or back in again, at any time by submitting your request to us in writing. Please contact us at privacy@castlighthealth.com to opt-out.

8. **For Public Health and Safety Purposes:** We may disclose protected health information to prevent or reduce a serious immediate threat to the health or safety of a person or the public, as permitted or required by law to:

a. Public health or legal authorities;

b. Protect public health and safety;

c. Prevent or control disease, injury, or disability;

d. Report vital statistics such as births or deaths; and/or

e. Report suspected abuse or neglect to public authorities.

9. **For Research:** We may disclose PHI to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

10. **For Substance Use Disorder (SUD) Patient Records:** To the extent that we create, receive, or maintain substance use disorder patient records protected (in compliance with 42 CFR Part 2), special privacy protections apply:

    a. **Treatment, Payment, and Health Care Operations (TPO):** We may use or disclose your SUD records for treatment, payment, and health care operations if you provide us with a single, broad written consent covering these activities. Redisclosure Notice: If we share your SUD records with an external recipient who is subject to HIPAA pursuant to your TPO consent, that recipient may further use or share your information in accordance with the HIPAA Privacy Rule. However, upon redisclosure, that information may no longer be protected by the stricter Part 2 rules.

    b. **SUD Counseling Notes:** A clinician's notes analyzing an SUD counseling session that are kept separate from the rest of your medical record require a separate, specific written authorization before they can be used or shared.

    c. **Strict Prohibitions on Legal Proceedings:** Your SUD records, or testimony relaying the content of those records, will not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide specific written consent for that purpose, or a court orders the disclosure. Any court order authorizing this disclosure must be accompanied by a subpoena or similar legal mandate compelling us to do so.

11. **For Workplace Injury or Illness:** Local and State laws require the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.

12. **Other Third-Party Disclosures to State, Regulatory and Federal Authorities:**

a. **Lawsuits and Disputes:** We are permitted (and may be required) to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order to the extent permitted by applicable law.

b. **Food and Drug Administration (FDA):** For problems with medications, food, supplements, and other products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.

c. **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.

d. **National Security:** We are permitted to release protected health information to federal officials for national security purposes, within the limits authorized by law.

e. **Law Enforcement:** We may disclose protected health information to law enforcement officials to the extent permitted by applicable law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.

f. **Coroners, Medical Examiners and Funeral Directors:** We may disclose protected health information to coroners and medical examiners to the extent permitted by applicable law. We may also disclose protected health information to funeral directors consistent with applicable law to allow them to carry out their duties.

g. **Organ-Procurement Organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.

h. **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.

i. **For Disaster Relief**: We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this NPP will generally only be made with your written authorization. Most uses and disclosures of psychotherapy notes and most uses and disclosures for marketing purposes fall within this category and require your authorization before we may use your medical information for these purposes. Also, the use or disclosure of PHI to conduct a criminal, civil, or administrative investigation or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or to identify any person for any of these purposes is prohibited. This prohibition also applies if we presume that the reproductive health care was lawful in accordance with applicable law. Additionally, with

certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your medical information without your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke (withdraw) that authorization, in writing, at any time. However, uses and disclosures made before your withdrawal are not affected by your action and we cannot take back any disclosures we may have already made with your authorization.

1. **De-identified Health Information:** We may use your health information to create "de-identified" information that is no longer identifiable to any individual in accordance with HIPAA. Once this information has been de-identified, we may use it or share with third parties to improve our services.
2. **Use of Unsecure Electronic Communications:** If you choose to communicate with us via unsecure electronic communication, such as regular email or SMS text message, we may direct you to contact us via a secure mechanism such as an online app, in our care centers, or over the phone. In addition, if you provide your email address or cell phone number when you consent to our services, we may communicate with you via phone call, emails or SMS text messages related to appointment reminders, benefit offerings, or other general informational communications. For your convenience, these messages may be sent unencrypted. Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices. By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis or treatment. Email communications should never be used in a medical emergency.

Your Rights Regarding Your Medical Information

Although, the health and billing records we create and store belong to us, the PHI generated in these records, generally belongs to you. As such, you have the following rights listed below.

To exercise any right, you must submit your request in writing to:

Castlight Health and Vera Whole Health
c/o Compliance & Privacy Department
1201 Second Avenue, Suite 1400
Seattle, WA 98101
or via email to: privacy@castlighthealth.com

1. **Right to Inspect and Receive a Copy of this NPP:** You have the right to receive, read, and ask questions about this Notice.

2. **Right to Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. Please note, that we are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply

with your request unless the information is needed to provide you emergency treatment or we are required or permitted by law to disclose it. We are allowed to end the restriction if we inform you that we plan to do so. If you request that we not disclose certain PHI to your health insurer and that PHI relates to a health care product or service for which we, otherwise, have received payment from you or on your behalf, and in full, then we must agree to that request.

3. **Right to Inspect and Receive a Copy of Your Records:** With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing records or any other of our records that are used by us to make decisions about you.

4. **Right to Request an Amendment:** If you feel the medical information we have about you is incorrect or incomplete, you may request that we amend this information. You have the right to request an amendment for as long as the information is kept by or for us in your medical and billing records or any other of our records that are used by us to make decisions about you. When you submit your request, please note that we cannot change what is in the record. We can, however, supplement information by an addendum. With your assistance, we may notify others who have the incorrect or incomplete medical information. We may deny your request if the medical information (i) was not created by us (unless the person or entity that created the medical information is no longer available to respond to your request); (ii) is not part of the medical and billing records kept by or for us; (iii) is not part of the information which you would be permitted to inspect and copy; or (iv) is determined by us to be accurate and complete. If we deny your request, we will give you a written explanation of why we did not make the amendment and explain your rights.

5. **Right to an Accounting of Disclosures:** You have the right to receive a list of certain disclosures we have made of your PHI in the six (6) years prior to your request. This list may not include every disclosure made, including those disclosures made for treatment, payment and health care operations purposes, or those disclosures made directly to you or with your consent. You must state the time period for which you want to receive the accounting. The first accounting you request in a 12-month period will be free, and we may charge you for additional requests in that same period.

6. **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. If you want us to communicate with you in a special way, you will need to give us details about how to contact you. You also will need to give us information as to how billing will be handled. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

7. **Right to Cancel Prior Authorizations to Use or Disclose Your PHI:** Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are committed to protecting the privacy of PHI we create or obtain about you. We are required by law to make sure your PHI is protected, give you this NPP, which describes our legal duties and privacy practices with respect to your PHI; and follow the terms of this NPP.

As such, the privacy practices described in this NPP will be followed by all of our professionals, employees, medical staff, trainees, contractors and consultants.

Changes To This Notice of Privacy Practices

We reserve the right to change our privacy practices and make updates to this NPP. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on our websites: https://apreehealth.com/wp-content/uploads/legal/notice-of-privacy-practices_april-2026-.pdf and https://apreehealth.com/wp-content/uploads/legal/notice-of-privacy-practices_april-2026-.pdf. In addition, at any time you may request a copy of the Notice currently in effect.

If you believe your privacy rights have been violated, you may discuss your concerns with us by delivering a written complaint to:

Castlight Health and Vera Whole Health
c/o Compliance & Privacy Departments
100 W Towne Ridge Pkwy, 2nd Floor,
Sandy, UT 84070
or via email to: privacy@castlighthealth.com

You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

PATIENT ACKNOWLEDGEMENT

- I acknowledge that I have read and understand the Notice of Privacy Practices described above.
- By signing this document, in-person or in an electronic format, I confirm that I have a clear understanding of how medical information about me may be used and disclosed by us, and how I can obtain access to the information collected by Castlight and Vera about me.
- I understand that acknowledging this Notice of Privacy Practices does not mean that I agree to any special uses or disclosures of my medical information that is not permitted by HIPAA.
- I also understand that I may refuse to sign this Acknowledgement, however my refusal does not prevent Castlight and Vera from using or disclosing my PHI as permitted by HIPAA.

Please note: If you refuse to sign the acknowledgement, we must keep a record of this fact.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

PATIENT RIGHTS AND RESPONSIBILITIES

We invite you (the "**member**" or "**patient**") to join us as a collaborative, active member of your care team. We encourage you to speak openly with your care team, take part in your treatment choices, and assert your rights in an effective manner. This document sets forth your patient rights and responsibilities.

Patient Rights

1. The right to receive considerate, respectful and compassionate care in a safe setting, regardless of age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
2. The right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
3. The right to be called by your proper name and pronouns and to be in an environment that maintains dignity and encourages positive self-image.
4. The right to be told the names and credentials of the members of the health care team directing and/or providing your care.
5. The right to be told by your healthcare provider about your diagnosis and possible prognosis, the benefits and risks of treatment, the alternatives for care or treatment, and the expected outcome of treatment, including unexpected outcomes.
6. The right to a form and manner of communication that you can understand.
7. If required, Castlight and Vera will provide sign language and foreign language interpreters as needed at no cost.
8. Information given will be appropriate to your age, understanding, and language.
9. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.
10. You have the right to give written informed consent before the start of certain non-emergency procedures and/or treatment.
11. You have the right to refuse treatment, to the extent permitted by law.
12. You have the right to be informed of the medical consequences of refusing treatment.
13. You have the right to grant your family and friends to participate in decisions about your care, treatment, and services provided.
14. You have the right to respectful, responsive care directed at fostering your comfort and dignity, including assessment and management of pain, and responding to your psychosocial, spiritual, and cultural concerns.

15. You have the right to full consideration of your privacy and confidentiality in care discussions, exams, and treatments.

16. Care discussion, consultation, examination and treatment are confidential and should be conducted discreetly, respecting your personal privacy. Those not directly involved in your care must have your permission to be present.

17. You have the right to see and get a copy of your medical records.

18. You may add information to your medical record and ask for information within your medical record to be corrected, if information is inaccurate.

19. You have the right to request a list of people to whom your personal health information was disclosed.

20. You have the right to expect that all communication and records about your care are confidential, unless disclosure is permitted by law.

21. You have the right to agree or refuse to take part in medical research studies.

22. You may withdraw from a study at any time without impacting your access to standard care.

23. You have the right to expect reasonable continuity of care, including the right to know in advance which of our health care providers and appointment times are available.

24. You can expect that Castlight and Vera will make a response to your request for services.

25. You have the right to make an advance directive and appoint someone to make healthcare decisions for you if you are unable.

26. If you do not have an advance directive, we can provide you with information and help you complete one.

27. You have the right to receive detailed information about charges you receive from us.

28. You have the right to bring forward ethical considerations and issues that may arise in the course of your health care.

29. You have the right to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment.

30. You have the right to withdraw consent up until a reasonable time before the item is used.

31. You have the right to voice your concerns about the care and/or service you receive, without fear of impacting your access to care or service.

Patient Responsibilities. To provide a safe and healthy environment for staff, patients and their visitors, we expect all individuals to refrain from behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. As a patient, you are subject to certain responsibilities:

1. You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security Number, insurance carrier and employer when it is required.

2. You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.

3. You are expected to ask questions if you do not understand information or instructions.

4. You are responsible for telling your care team if you believe you cannot follow through with your treatment plan.

5. You are responsible for following your treatment plan and/or for communicating barriers to your treatment plan to your care team.

6. You are expected to actively participate in your care plan, including pain management, and to keep your health care providers informed of the effectiveness of your treatment, as necessary.

7. Upon interactions, you are expected to treat all staff, other patients, and visitors with courtesy and respect;

8. You are expected to abide by all of our rules and policies as they have been communicated to you.

9. You are expected to be mindful of noise levels, privacy, and conduct.

10. You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.

11. You are expected to provide complete and accurate information about your health insurance coverage and to notify us if there are any changes.

12. You are also expected to complete all authorizations and release of medical information forms requested by us and/or your insurance carrier, to pay any required co-payments at the time of service and to pay subsequent charges in a timely manner.

13. You have the responsibility to supervise your children and any other visitors accompanying you, if applicable.

We have a zero-tolerance policy for aggressive behavior directed against others, including patients, visitors or our staff. You understand that the following, but not limited to, inappropriate and/or illegal behaviors are strictly prohibited:

1. Possessing firearms or any weapon.
2. Intimidating or harassing staff or other patients.
3. Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication.
4. Physically assaulting or threatening to inflict bodily harm.
5. Making verbal threats to harm another individual or destroy property.
6. Damaging business equipment or property.
7. Making menacing or derogatory gestures.
8. Making racial or cultural slurs or other derogatory remarks.
9. Any actions that make staff or others feel unsafe or uncomfortable, or any conduct that we consider offensive, capable of causing harm, or in conflict with our internal safety policies and procedures.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report them to any staff member immediately in person or online at https://www.verawholehealth.com/contact. At our sole discretion, violators may be subject to removal from the facility (including offsite events) without notice and/or discharged from the clinic upon reasonable written notice. In the event a patient is discharged by us for violating their patient responsibilities, we may provide reasonable patient assistance to transfer their care to a new provider.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and understand the Patient Rights and Responsibilities listed above. I understand that the full list of enumerated rights and responsibilities may not be listed above, but that this includes the general nature of rights and responsibilities which I should abide by. By signing this document, in-person or in an electronic format, I confirm that I have a clear understanding of my rights and responsibilities.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

AUTHORIZATION TO RECEIVE SERVICES

The following **Authorization to Receive Services** form authorizes us to provide healthcare and coaching services that it performs in its capacity as my healthcare provider, including those services performed virtually, via a telehealth or telemedicine visit (collectively referred to as "**Services**"). Those Services may include, but are not limited to the following:

- Administration and performance of all relevant diagnoses and treatments;
- Administration of prescribed medication;
- Performance of such procedures as may be deemed necessary or advisable in my treatment, by my provider(s);
- Performance of diagnostic procedures/tests and cultures; and/or
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or her/his assigned designees.

General Visits (In-Person or Virtual):

- I fully understand this information is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continuing in nature even after a specific diagnosis has been made, treatment recommendations including alternatives to treatment have been discussed, and possible risks have been addressed.
- I understand that this document will become a part of my medical record.
- I understand that my medical information, as is minimally necessary, may be used and disclosed for healthcare treatment, payment or operations.

Telehealth Visits (if applicable):

- I understand that the same standard of care applies to any telehealth or telemedicine visit as it does to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider.
- I will be notified in advance, if anyone other than my provider(s) are present in the room.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
- If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telehealth visit and make other arrangements to continue the visit.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and understand the **Authorization To Receive Services** as listed above. I understand that the full list of enumerated rights and responsibilities may not be listed above, but that this includes the general nature of rights and responsibilities which I should abide by. By signing this document, in-person or in an electronic format, I attest that I have a clear understanding of its contents and have had my questions (if any) answered to my satisfaction.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

AUTHORIZATION TO AUDIO RECORD SERVICES

This **Authorization to Audio Record Services** form is provided to obtain your authorization to allow your Care Team, such as your provider (and as further defined in our Terms of Use) to audio record relevant details of your appointment. These recordings may capture PHI shared during your visit, such as medical background, symptoms, diagnoses, therapeutic interventions, and care strategies, or as further described in the AARS documentation.

Patient Audio Recording Terms & Conditions:

- ☐ We utilize a third-party, HIPAA-compliant medical dictation platform powered by artificial intelligence (AI) to record Services, enhancing the precision and efficiency of our clinical documentation.
- ☐ AI-assisted audio recording is restricted to telehealth (virtual) visits and in-person clinical appointments.
- ☐ Recordings are used as outlined in our Notice of Privacy Practices (NPP) and under HIPAA guidelines for: i) medical treatment and care continuity; and ii) organizational operations like provider collaboration, quality audits, and clinical documentation.
- ☐ Clinical details from these recordings are never used for research or marketing, nor are they shared externally except as authorized by HIPAA.
- ☐ All audio data is stored securely and automatically purged after sixty (60) days per our data retention standards.

By consenting to this form, you understand and agree:

- Agreement to this recording is entirely voluntary. You may decline or rescind your authorization at any time without impacting your access to treatment or care.
- If you request that a companion or third party be present during a recorded session, their verbal consent is also required and will be notated by your provider.
- Withdrawing consent will stop future recordings immediately; resuming audio documentation at a later date would require completion of a new form.
- **Restriction on Personal Recording.** While you may authorize your provider to audio record your session, this does not grant you reciprocal permission to record them. Personal recording (both audio and video) is strictly prohibited.

PATIENT ACKNOWLEDGEMENT

Please select one:

- ☐ I acknowledge that I have read and understand the **Authorization to Audio Record Services** form as listed above. By signing this document, in-person or in an electronic format, I acknowledge that my Services may be being recorded for purposes of assisting my provider and medical staff in the creation of a summary of the treatment and care I receive. I further attest that I have a clear understanding of its contents and have had my questions (if any) answered to my satisfaction.
- ☐ I have read and do not authorize the **audio recording of my appointment Services as detailed** above.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

AUTHORIZATION TO RELEASE PHI

In alignment with our Notice of Privacy Practices, we may disclose your PHI for Treatment, Payment and Healthcare Operations ("**TPO**") purposes, or as required by law. In certain circumstances, your written authorization is required before we may release your PHI to any third party for other purposes beyond TPO. Third parties where we may release your PHI with authorization, include, but are not limited to:

- Attorneys, legal representatives, or for use in court proceedings.
- Life, disability, or auto insurance companies.
- Employers (for sick leave, fitness-for-duty, or employment verification).
- Schools or non-medical third parties at your direct request.
- Marketing, fundraising, or commercial entities.

Please note: Highly sensitive records (such as psychotherapy notes, substance abuse treatment, or HIV status) do not fall under the TPO purpose, and require your explicit initials, in addition to your written authorization via this form.

Instructions: You may choose to complete this authorization either today or at a future time if you wish to authorize the release of your PHI to a third party (as described above). If you complete this form at this time, a separate release form will be required should you choose to authorize the release of your PHI to a third party other than the one specified below.

Patient Information

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: (_____) _____ - _____

Address: _____

1. Authorization & Purpose

I hereby authorize **Castlight Health and/or Vera Whole Health** to:
(Please check one or both)

- ☐ [ ] **Release/Disclose** my protected health information to:
- ☐ [ ] **Receive/Obtain** my protected health information from:

Name of Individual/Organization: _____

Address: _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

Purpose of Disclosure: (e.g., Continuity of care, transfer of care, personal use, legal proceedings, insurance, etc.)

_____

2. Information to be Released

Please check the boxes that apply to the records you wish to share:

- ☐ [ ] Complete Medical Record (all records)
- ☐ [ ] Progress Notes / Office Visit Notes
- ☐ [ ] Lab / Pathology Reports
- ☐ [ ] Diagnostic Imaging Reports (X-ray, MRI, CT)
- ☐ [ ] Billing & Financial Records
- ☐ [ ] Mental Health Records (excluding Psychotherapy notes)
- ☐ [ ] Alcohol/Drug Treatment Records
- ☐ [ ] Occupational Health (Work-Related) Records
- ☐ [ ] Genetic Testing Records
- ☐ [ ] Other (please specify): _____

Highly Sensitive Information (Requires Explicit Initials):

By initialing below, I specifically authorize the release of the following highly protected information, if applicable to my record:

- ☐ _____ Mental/Behavioral Health Records
- ☐ _____ Substance Abuse / Alcohol Treatment Records
- ☐ _____ HIV/AIDS Testing or Treatment Information

3. How will the Information be Released

- ☐ [ ] Mail _____
- ☐ [ ] Fax _____
- ☐ [ ] Portal _____
- ☐ [ ] Other _____

4. Specific Dates of Service (Optional):

[ ] All dates of service **OR** [ ] From: ____/____/____ To: ____/____/____

PATIENT ACKNOWLEDGEMENT

Please read and initial the following statements:

8. _____ **Revocation:** I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.
9. _____ **Voluntariness:** I understand that signing this form is voluntary and I do not have to authorize the release of my PHI. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, unless I receive research-related treatment or the purpose of the healthcare I receive is to create information to disclose to another.
10. _____ **Redisclosure:** I understand that once my health information is disclosed, it may no longer be protected by federal privacy regulations (HIPAA) and could potentially be redisclosed by the recipient.
11. _____ **Expiration:** Unless otherwise revoked in writing, this authorization will expire **one (1) year** from the date of signing, or upon the following specific event/date: _____.

By signing below, I acknowledge that I have read and understand this form, and I authorize the disclosure of my PHI as specified above.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

FINANCIAL RESPONSIBILITY AGREEMENT

To the extent applicable to you based on your employer-sponsored benefits, this **Financial Responsibility Agreement** outlines your financial obligations, in which we require that you read and agree to, before any Services from us are rendered to you. If your employer-sponsored benefits do not require any financial responsibility payable by you, then you may indicate as such by checking off the relevant acknowledgement box on the following Patient Acknowledgement page.

Pursuant to the Health Insurance Portability and Accountability Act ("**HIPAA**"), payment of your bill is considered part of the healthcare activities. As such, any use and disclosure of your financial responsibilities will be protected in the same manner as details of your medical information, such as any treatment you may receive.

To the extent that you have Medicare and/or Medicaid coverage as either your primary or secondary insurance in addition to your employer plan, our billing will comply with CMS requirements. By signing this Agreement, you acknowledge and agree that you remain personally accountable for any copays or patient responsibility amounts required under your Medicare and/or Medicaid coverage.

Payment: Fees are payable when services are rendered. We accept cash, check, credit cards, Flexible Spending Accounts (FSA), Health Savings Accounts (HSA) and Health Reimbursement Accounts (HRA), or pre-approved insurance, for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

Payment for Minors: The responsible party for a minor child (a child that is under 18 years of age except for an emancipated minor) is the parent that presents the child for care at the time of the initial visit. If the parent presenting the child brings a custody order stating that the other parent is financially responsible for the minor child's medical bills, the responsible party is changed to the parent designated in the custody order.

Insurance Coverage: Proof of insurance and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. It is your responsibility to know your insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, and any exclusions in your insurance policy. We will attempt to confirm your insurance coverage prior to treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you may be financially responsible. If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

PATIENT ACKNOWLEDGEMENT

Please select one:

- ☐ I acknowledge that I have read and understand the **Financial Responsibility Agreement** contained above. By signing this document, in-person or in an electronic format, I confirm that I have a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services rendered to me, I assume financial responsibility and will pay all charges in full. I also certify that I have read and have had the opportunity to ask questions about the terms contained in this consent and Agreement. I fully understand its terms and voluntarily agree to this Agreement.
- ☐ I acknowledge that I have no financial responsibility based on the employer-sponsored benefits provided to me.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

PATIENT MESSAGING AUTHORIZATION

We may have the ability to communicate with you via email, SMS text, and/or phone calls to remind you of your appointments, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters. Please note, we will not share confidential details such as your diagnosis, test results or other medical claims details via email or SMS text, however we may direct you to review your confidential information by logging into your secure patient portal by email or SMS text.

By providing us with your email address and/or cell phone number below, you are authorizing us to communicate with you via these means.

E-mail: _____

Cell Phone:_____ (*please check the boxes below to also authorize us to send you text messages or contact you by phone call and/or leave detailed messages on your voicemail*)

- ☐ _____ SMS Text Messages
- ☐ _____ Calls
- ☐ _____ Detailed Voicemail Messages

We will use reasonable means to protect the security and confidentiality of information sent and received. However, because communicating with patients by email, SMS text, or over the phone may not be secure, we cannot guarantee the security and confidentiality of electronic communications:

PATIENT ACKNOWLEDGEMENT

Please select one:

☐ I authorize Castlight and Vera to send electronic communications in the form of emails, SMS texts, phone calls, and/or voicemail messages as indicated by me above. I understand that this request to receive electronic communication in the forms outlined above will apply to all future updates, unless I request a change.

a. I understand that communications from Castlight and Vera in this form may not be encrypted and there is a potential risk of messages being intercepted by a third party. Despite this, I agree to communicate with Castlight and Vera in this manner,with a full understanding of that risk.

b. I understand that I may revoke this authorization at any time.

☐ I do not authorize electronic communications by the method(s) identified above.

X _____ _____

Name of Patient (Print) **Date**

X _____

Signature of Patient

X _____

Legally Authorized Representative (Print)

X _____

Signature of Legally Authorized Representative

HOW DID YOU HEAR ABOUT US ?

We are excited to provide Services to you. To help us ensure that we are effectively engaging our Patients and Members, please indicate how you discovered us.

Please select all that apply.

- ☐ Email
- ☐ Text message
- ☐ Phone call
- ☐ Letter or postcard
- ☐ Digital ad
- ☐ Social Media
  - ☐ LinkedIn
  - ☐ Facebook
  - ☐ Instagram
  - ☐ X (formerly “Twitter”)
  - ☐ Threads
- ☐ Family member or friend
- ☐ Employer or union
- ☐ Health insurance provider
- ☐ Referral
- ☐ Event
  - ☐ Employer or union event (please specify _____)
  - ☐ Community event (please specify _____)
- ☐ Billboard
- ☐ Other: (please specify _____)

SPECIAL NOTICES UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT

NOTICE OF NON-DISCRIMINATION

- For the most current version of our statement on non-discrimination, please visit the Non-Discrimination Notice.

NOTICE OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

- For the most current version of language services, please visit the Notice of Availability.

Version Control - July 7, 2026 updates include:

- New table of contents identifying each section on cover page
- Revised NPP to include Substance Use Disorder Patient Record disclosures
- Revised Patient Responsibilities to include catch all for unwelcomed behavior.
- Revised Financial Agreement to include Medicare/Medicaid coverage details
- Authorization to Audio Record Services includes restriction on personal recording
- Added Notice of Non-Discrimination and Notice of Language Availability