

Medication Kit Consent

You have disclosed all your known health conditions, allergies and medications you are taking, including herbal medications/supplements. You understand that certain treatment options that You may receive from or medications prescribed to You by your Provider can be dangerous and may result in medical care that is unnecessary if You have misrepresented your current health care condition and status. You have truthfully supplied information about your health care condition and status when answering any questions either on Platform or during any examination with a Provider.

Consent to remote treatment:

I hereby consent to remote diagnosis, treatment and education by Divine Health Group and its affiliates through the use of synchronous and asynchronous audio and video communication commonly known as telehealth or telemedicine technology (collectively, telehealth technology). I acknowledge that diagnosis, treatment and education through the use of telehealth technology will involve collecting information, including protected health information. I acknowledge my health information will be transmitted, stored and reviewed in compliance with applicable laws. I acknowledge that while telehealth technology may improve access to care and treatment outcomes, as with any technology facilitated diagnosis, treatment and/or education, there are risks and results cannot be guaranteed. The risks associated with telehealth technology include, and are not limited to, technical problems and equipment malfunctions that may result in omission, loss or compromise of information necessary for my diagnosis, treatment or education and that such omission, loss or compromise of information may result in my injury or death. I understand it is my responsibility to clearly explain symptoms, medical/surgical history and allergies, and to provide any other information as needed for your treatment plan.

LIMITATION ON LIABILITY AND DISCLAIMER OF WARRANTIES

I understand by placing an order and/or participating in the Divine Health Group service, you agree Divine Health Group and its owner(s), parent, subsidiaries, affiliates, agents, representatives, and employees will have no liability whatsoever for any injuries, losses, claims, damages or any special, exemplary, punitive, Indirect, incidental or consequential damages of any kind.

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment. I also understand that any treatment performed is between me and the healthcare provider who is treating me and I will direct all questions or concerns to the treating clinician.

I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I with this medical kit I will utilize the Medical Kit Guide and education provided to treat symptoms only as discussed and understand the risks of over use of medication.

I understand that I have alternative treatment options available outside of Divine Health Group, including but not limited to Emergency Room services, Primary Care, and specialty care. I also understand that results are not guaranteed.

I understand that the Medication guide is not intended to replace emergency care. For any life-threatening emergencies I will contact 911 or present to your nearest emergency room.

I understand that if I take the recommended medication and symptoms do not begin to improve in 48 hours, I will present to my local healthcare clinic or emergency room.

If there is a medical Emergency I will present to the nearest Emergency Room.

I accept the risks and complications of telehealth and prepaid medical kit indicated treatment and understand that no guarantees are implied as to the outcome of the treatment. I also certify that if I have any changes in my medical history, I will notify the healthcare professional who treated me immediately.

I voluntarily request and consent to health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that are received.

Acknowledgement

By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I understand that depending on reported allergies and providers specific recommendations, my kit may contain the following medications.

- Amoxicillin 250 mg tablets
- Azithromycin 250 mg tablets
- Doxycycline 100 mg capsules
- Fluconazole 150 mg tablets
- Metronidazole 500 mg tablets
- Nystatin Ointment 100MU 15grams
- Ondansetron 4 mg tablets
- Sulfamethoxazole/Trimethoprim 400mg/80mg tablets
- Triamcinolone 0.1% Cream 15 grams

I am aware that the shelf-life of most medications is optimized at room temperature 68-77°F (20-25°C) and when protected from UV light. I will store medication in a cool, dark & dry place

By my signature below, I consent to the administration of the prescribed medication in the home setting following a provider evaluation. I also release Divine Health Group LLC and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this medication kit.

I understand that:

- I have voluntarily chosen to receive the medication.
- I am of legal age and authorized to execute this consent form.
- I will immediately alert the staff at DHG of any medical conditions which may adversely affect my personal health or effectiveness of the medication.
- I have received education about potential side effects of the medication, when they may occur, and when and where I should seek treatment. I understand that if I experience any side effects, I am responsible for following up with my prescriber at my expense.

- I have had the opportunity to ask questions about the medication, and all my questions have been answered.
- I understand the benefits and risks of the medication kit.

Name_____

Date of Birth_____

Name of Individual Authorized to Sign for Patient