DIRECT PAY PLAN ENROLLMENT FORM

reSET® reSET-O®

Phone: 1-833-MY-RESET • **Fax:** 1-877-256-1320
Email: PearConnect@PearTherapeutics.com
Hours of Operation: Monday through Friday, 8AM - 8PM ET

* Indicates a required field.

Please complete all fields indicated to prevent any delays in filling the prescription. Once form is completed, please fax to 877-256-1320.

PATIENT

*Name: (First, Middle Initial, Last) _____

Sex: ☐ M ☐ F *DOB: ___/___/___ *Address: _____ Apt/Suite: _____

*City: _____ *State: _____ *ZIP: _____ *Email: _____

*Cell Phone: _____ Alt Phone: _____

☐ Okay to leave a reSET Connect™ voicemail†

† I authorize reSET Connect to leave a detailed voicemail message for me at the numbers provided above. I understand that the message may include any information, including my personal information and information about my use of reSET Connect. I also understand that, if others have access to my voicemail, there is a possibility that they may hear a message left by reSET Connect.

FOR PATIENTS PAYING WITH DEBIT OR CREDIT CARD ONLY

Please enter your billing information below to pay directly without the aid of insurance.

BILLING INFORMATION ☐ Billing address is the same as patient address

*Name: (First, Middle Initial, Last) _____

*Address: _____ Apt./Suite: _____

*City: _____ *State: _____ *ZIP: _____ *Phone Number: _____

*Card Number: _____ *Expiration Date: _____ *Security Code: _____

*Authorized Signature: _____

SIGN HERE TO AUTHORIZE DIRECT PAY PLAN AND PATIENT ATTESTATION

CANNOT PROCESS FORM WITHOUT THIS COMPLETED

☐ I have read and agree to the Telephone Consumer Protection Act (TCPA) consent on page 3 (optional).

PLEASE SELECT DIRECT PAY OPTION

PATIENT ATTESTATION: I attest that I do not have insurance or I will not seek reimbursement from Medicaid, Medicare, Medigap, VA, DoD, TriCare, private indemnity, or any other third-party program either directly or indirectly for reSET® or reSET-O® or services rendered in connection with said therapies.

☐ **One (1) Time Charge:** You authorize the merchant below to make a one-time charge to your Credit Card listed above. By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account. I authorize EnvoyHealth Management, LLC to charge my Credit Card above for $ _____.

☐ **Recurring Charge:** You authorize regularly scheduled charges to your Credit Card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card Statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected. I authorize EnvoyHealth Management, LLC to charge my Credit Card above for $ _____ beginning on the _____ of every month.

X _____ _____/_____/_____

Patient/Legal Guardian Signature **Date of Signature (MM/DD/YYYY)**

I have read and agree to the attached Patient Authorization (page 3).

_____

***Name Printed**

PEAR THERAPEUTICS | SANDOZ A Novartis Division

PHYSICIAN

* Indicates a required field.

LICENSED CLINICIAN

*Name: _____

*Clinic/Practice: _____

NPI #: _____

Contact Person: _____

Office Phone: _____

Fax: _____

*Email: _____

Cell Phone: _____

*Address: _____

Apt/Suite: _____ *City _____

*State: _____ *ZIP: _____

ADDITIONAL CLINICIAN OR THERAPIST (OPTIONAL)

☐ N/A

*Name: _____

*Clinic/Practice: _____

NPI #: _____

Contact Person: _____

Office Phone: _____

Fax: _____

*Email: _____

Cell Phone: _____

*Address: _____

Apt/Suite: _____ *City _____

*State: _____ *ZIP: _____

*Contingency Management (select one): ☐ Virtual Nonmonetary Rewards ☐ Digital Monetary Gift Card Rewards

DIAGNOSIS

Diagnosis: _____

*Primary ICD-10 Code: _____

Secondary ICD-10 Code: _____

☐ **If primary diagnosis is alcohol use disorder (AUD), check here for additional substance use and indicate in a secondary ICD-10 code.**

Previous Treatments Tried and Failed:

☐ Inpatient treatment
☐ Intensive outpatient therapy
☐ Outpatient therapy at _____ (Insert facility)
☐ Attends/attended NA or AA meetings
☐ Outpatient group therapy
☐ Drug and alcohol counseling
☐ Medication-assisted treatment
☐ Other, please specify: _____

reSET® OR reSET-O®

☐ *__reSET__ 12-week digital therapy
Complete therapy lessons as directed

DISPENSE: One access code good for 90-day therapy

OR

☐ *__reSET-O__ 12-week digital therapy
Complete therapy lessons as directed

DISPENSE: One access code good for 84-day therapy

☐ *Confirm patient is taking buprenorphine.

LICENSED CLINICIAN ATTESTATION:

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By completing this form, I certify that my patient is aware of the disclosure of their personal health information to Pear Therapeutics, Sandoz, and their business partners for reSET Connect patient support services. I further certify that (a) any service provided through reSET Connect on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use reSET or any Pear Therapeutics or Sandoz product or service for anyone, and (b) my decision to prescribe reSET was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement from Medicaid, Medicare, Medigap, VA, DoD, TriCare, private indemnity, or any other third party program either directly or indirectly for reSET or reSET-O or services specifically related to reSET or reSET-O .

*Licensed Clinician Signature: _____ *Date: _____

*Licensed Clinician Name Printed: _____

Patient Authorization I give permission for my health care providers (HCPs), pharmacy, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Pear Therapeutics, Sandoz, and reSET Connect, their affiliates, business partners, and agents (referred together as "reSET Connect") so that reSET Connect can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with reSET, (ii) coordinate my receipt of and payment for reSET, (iii) facilitate my access to reSET, (iv) support me and provide me with information about reSET and my module completion, disease awareness, management programs, and educational materials, (v) manage the reSET Patient Service Center, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the reSET Patient Service Center, and (viii) to send me information about programs that might help me pay for my reSET therapy, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for my reSET therapy, government agencies, and insurance companies for purposes of providing or facilitating this assistance. I give permission to reSET Connect to disclose my Personal Information to my pharmacy, health care providers, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to reSET Connect to combine or aggregate any information collected from me with information reSET Connect may collect about me from other sources for the purpose of providing or administering all necessary and important patient services. I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from reSET Connect in exchange for disclosing my personal information to reSET Connect and/or for providing me with therapy support services. I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to reSET at any time in the future by calling 1-833-MY-RESET (1-833-697-3738) or by emailing us at PearConnect@PearTherapeutics.com. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in reSET Connect. If I revoke this authorization, reSET Connect will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that reSET Connect may change or end at any time without prior notification. I understand that I may receive a copy of this authorization. I agree to be contacted by reSET Connect by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Enrollment Form for all purposes described in this Patient Authorization. I also agree to be contacted by reSET Connect and others on its behalf by telephone calls, emails, and text messages, made by or using an automatic telephone dialing system or pre-recorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify reSET Connect promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that reSET Connect does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing and non-marketing calls and texts from and on behalf of reSET Connect, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of 3 to 10 messages per week. Message and data rates may apply. Privacy Policy at www.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help.

reSET Connect and Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" authorizing reSET Connect and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by reSET Connect. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call reSET Connect at 1-833-MY-RESET. If eligible, I would like to be considered for programs administered by reSET Connect.