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, 8 AM - 8 PM 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: _____ *Email: _____

*Address: _____ Apt/Suite: _____

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

*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

PATIENT AUTHORIZATION (MANDATORY)

Please read the authorization for use and disclosure of health and other personal information on the back of this form.

☐ _____ I have read and agree to the Patient Authorization on page 3.

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)**

_____

***Name Printed**

_____

Clinic/Practice

PEAR THERAPEUTICS

Patient Name

reSET reSET-O

* Indicates a required field.

PHYSICIAN

LICENSED CLINICIAN

*Prescriber Name: _____

*NPI: _____

*Email: _____

*Clinic/Practice: _____

*Address: _____

Apt/Suite: _____ City: _____

State: _____ ZIP: _____

Office Contact Person: _____

Email: _____

Office Phone: _____

ADDITIONAL CLINICIAN OR THERAPIST (OPTIONAL)

☐ N/A

*Name: _____

NPI: _____

*Email: _____

*Clinic/Practice: _____

*Address: _____

Apt/Suite: _____ City: _____

State: _____ ZIP: _____

Office Contact Person: _____

Email: _____

Office Phone: _____

*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 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.

PRESCRIBER AUTHORIZATION (MANDATORY):

I authorize reSET Connect on behalf of my patient to furnish any information on this form to the insurer of the above-named patient and to send the access code for reSET/reSET-O to the above-named patient. I certify that the rationale for prescribing reSET/reSET-O is the following, based on my selection above in the Prescription box:

If reSET – to provide cognitive behavioral therapy, as an adjunct to a contingency management system, for patients 18 years of age and older who are currently enrolled in outpatient treatment for Substance Use Disorder (SUD) under the supervision of a clinician. reSET is not intended to be used as a stand-alone therapy for SUD or as a substitute for medication. Additionally, reSET is intended for patients whose primary language is English and have access to an Android/iOS tablet or smartphone.

If reSET-O – to increase patient's adherence to outpatient treatment for Opioid Use Disorder (OUD) by providing cognitive behavioral therapy, as an adjunct to outpatient treatment that includes transmucosal buprenorphine and contingency management, for patients 18 years of age or older who are currently under the supervision of a clinician. reSET-O is not intended to be used a stand-alone therapy for OUD and does not replace care by a licensed medical practitioner or represent a substitute for a patient's medication. Additionally, reSET-O is intended for patients whose primary language is English and have access to an Android/iOS tablet or smartphone.

By my signature I also acknowledge that I have obtained the patient's authorization or consent, as necessary, to release the above information and such other information as may be required by reSET Connect.

*Licensed Clinician Signature: _____ *Date: _____

*Licensed Clinician Name Printed: _____

PATIENT AUTHORIZATION:

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my Protected Health Information ("PHI"), including but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Pear Therapeutics, Inc. and its representatives, agents, and contracted third parties (together "reSET Connect"), to only be used for the following:

- Providing reimbursement support associated with the filling of my prescription for reSET/reSET-O, including the performance of a preliminary insurance verification and the securing of any insurance coverage for reSET/reSET-O to which I am entitled.
- Facilitating the provision of patient assistance, reduced cost medication and/or other reSET/reSET-O-related services offered by reSET Connect.
- Facilitating my access to reSET/reSET-O, by providing me with information about reSET/reSET-O and my module completion, disease awareness, management programs, and educational materials.
- Providing me with adherence reminders and support.
- Conducting quality assurance, surveys, and other internal business activities in connection with the reSET Connect.
- Improving the overall patient experience from enrollment to use of reSET/reSET-O and for analyses and in publications, provided that my information is aggregated with other data and does not contain any personal identifying information.

By signing this authorization, I authorize reSET Connect to disclose my PHI, including but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription, in addition to household income and size, to my health plans, physicians, and pharmacy providers, Envoy Health Management, LLC, Diplomat Pharmacy, Inc., Experian Health, and certain other third-party contractors and their representatives, agents, and contracted third parties to only be used for the following:

- Providing reimbursement support associated with the filling of my prescription for reSET/reSET-O, including the performance of a preliminary insurance verification and the securing of any insurance coverage for reSET/reSET-O to which I am entitled.
- Facilitating the provision of patient assistance, reduced cost medication and/or other reSET/reSET-O-related services offered by reSET Connect.
- Facilitating my access to reSET/reSET-O, by providing me with information about reSET/reSET-O and my module completion, disease awareness, management programs, and educational materials.
- Providing me with adherence reminders and support.
- Conducting quality assurance, surveys, and other internal business activities in connection with the reSET Connect.
- Improving the overall patient experience from enrollment to use of reSET/reSET-O and for analyses and in publications, provided that my information is aggregated with other data and does not contain any personal identifying information.
- Providing information technology support that may require access to my PHI.

By signing this form, I understand that once my health plans, physicians, and pharmacy providers, or reSET Connect, have disclosed my PHI to the parties specified herein, that information may no longer be protected by certain federal and state privacy laws , although certain other federal protections may apply. reSET Connect agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law, and to notify other parties to whom reSET Connect discloses the information of reSET Connect's obligation to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law. I understand that I may refuse to sign this authorization and that my health plans, physicians, and pharmacy providers will not condition treatment, payment, or eligibility for benefits on my signing this authorization, but that if I do not sign this authorization, I will not be able to obtain reSET Connect services. I understand that I am entitled to a copy of this authorization. I also may revoke (cancel) this authorization at any time in the future by calling 1-833-MY-RESET (1-833-697-3738) or by emailing PearConnect@PearTherapeutics.com, but that this cancellation will not apply to any information already used or disclosed in reliance on this authorization before notice of the cancellation is received by my health plans, physicians, and pharmacy providers, or reSET Connect. I also understand that reSET Connect will no longer be able to provide me with services if I cancel my authorization. I authorize reSET Connect and its healthcare partners to forward the prescription provided by my physician, by fax or by another mode of delivery, to the pharmacy. I understand that this authorization will remain valid for seven (7) years after the date of my signature, unless applicable law requires an earlier expiration or I revoke my authorization earlier. I also understand that the services offered by reSET Connect may change or end at any time without prior notification.

I authorize reSET Connect to provide me with support services related to any Pear products, including, but not limited to: educational support provided in-person, online, or by telephone; financial assistance services; and product support services; as well as any information or materials related to such services. I authorize reSET Connect to contact me to provide such services and information by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone-dialing system or a prerecorded voice) (average of 3-10 messages per week) (standard message and data rates may apply; I may opt out at any time by sending an e-mail with subject line "STOP" to PearConnect@PearTherapeutics.com and I understand that I am not able to opt out by directly replying to any text message). I also authorize the disclosure of my personal health information to specific individuals that I have designated.

Please find more information on reSET-O at https://peartherapeutics.com/reset-o-pt-privacy/ and https://peartherapeutics.com/reset-o-pt-terms/. Please find more information on reSET at https://peartherapeutics.com/reset-pt-privacy/ and https://peartherapeutics.com/reset-pt-terms/.

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.