# Patient Enrollment Through Sargas Patient Care

Fill out the form below to enroll with Sargas patient care, a patient-support program. S.P.A.C. International will provide frequent communications and tools to help you manage your therapy. In addition to the information already provided by your health care team, you'll also have access to a registered clinically trained staff who can provide you with information regarding your treatment.

Please complete all required fields*

| | | | |
|---|---|---|---|
| Service * | Covid-19 ▼ | | |
| Physician Name* | First and Last Name both | Physician Phone Number* | |
| First Name * | | Last Name * | |
| Street Address * | | City * | |
| State * | | Zip * | |
| E-mail Address * | | DoB * | mm/dd/yyyy |
| Daytime Phone * | | | |
| Evening Phone * | | Cell Phone | |
| Best time to Call | | SPAC can leave messages on my phone * | ◉ Yes ○ No |

**Patient Authorization**

I verify that the information provided in this enrollment form is current, complete, and accurate. I understand S.P.A.C. International reserves the right at any time, and without notice, to modify or discontinue the Sargas patient care Program with respect to any patient (including me), or to modify or discontinue the program entirely.

I authorize the Sargas patient care Program to use and obtain my protected health information from my prescribing physician, insurance company, specialty pharmacy and other sources as deemed necessary to ensure the accuracy and completeness of this enrollment form, to provide services to me, and to otherwise administer the Sargas patient care Program.

### I authorize SPAC international and the Sargas patient care Program to do the following:

Use and give out my information where necessary and to send me information or materials related to my treatment (or any other related products or services in which I might be interested).

Contact me occasionally to get my feedback (for market research purposes) about my medication or the Sargas patient care Program.

Operate and improve the quality of the Sargas patient care Program, or otherwise as required or permitted by law.

My samples, genomic and Genetic data and health information will be stored and shared with other researchers. The samples and information will be available for any research question, such as research to understand what causes certain diseases (for example heart disease, cancer, or psychiatric disorders), development of new scientific methods, or the

study of where different groups of people may have come from. There are no plans to compensate me and I hereby authorize use of my genetic, tissue and genomic information for research purposes. All my health information will be released anonymously. If research finds benefits for my health than I authorize S.P.A.C. International and its representative to contact me immediately.

I acknowledge that I am a legal resident of the United States. I authorize my healthcare providers, insurance companies, and specialty pharmacies to use and disclose to S.P.A.C. international, the Sargas patient care Program and their authorized agents and assignees, all medical records and financial information with respect to my treatment, my eligibility for assistance, the coordination of my treatment (and the receipt of my medication), and my participation in the Sargas patient care Program for the purposes of providing services to me and otherwise administering the program. I understand that my healthcare providers and insurance company will not modify my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to enroll in the Sargas patient care Program.

If I do not wish to receive information related to my medication (or any related products or services) or to be contacted occasionally for market research purposes, I may call the Sargas patient care Program's phone number (661) 320-4477 during business hours.

- [x] My COVID-19 provider is ______________________.
  I acknowledge in writing that the provider has explained the following:
- [x] The nature of COVID-19 services and my portal login for Chronic Care Management Cloud ®
- [x] Only one provider at a time can furnish COVID-19 for the beneficiary. and I designate Dr ______________________ to provide my COVID-19 services via Chronic Care Management Cloud ®.
- [x] I designate Dr ______________________ to provide my COVID-19 services via Chronic Care Management Cloud ®.
- [x] My health information will be shared with other providers for care coordination purposes.
- [x] I may stop COVID-19 services at any time by revoking consent, by informing my current COVID-19 provider in writing, effective at the end of then-current calendar month.
- [x] I will be responsible for any associated co-payment or deductible.

(•) Signature ( ) Verbal
Consent

Signature

______________________

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