SABI Mind : Equity Access Program Application

Discover New Wholeness

First Name: _____

Last Name: _____

Phone Number: _____

Email: _____

Confirmation of need for financial assistance

- By completing this form, you confirm that you would like to participate in SABI Mind's Equity Access Program (EAP) and that you are seeking additional financial support through the program.
- SABI Mind may make changes to its EAP discounts and pricing or terminate its EAP program at any time
- SABI Mind may terminate your participation in the EAP program should we find claims of need that are false or misleading
- You agree to provide SABI Mind with verification of income, should it be requested and failure to do so will result in you no longer being eligible to participate in the EAP program

I acknowledge that SABI Mind is a provider of medical and psychological services including Ketamine-Assisted Therapy. As such, I acknowledge that SABI Mind is responsible for completing all registrations and transactions.

By signing this application form, I acknowledge that I have read and understand the information below and consent to the collection, use and disclosure of my personal information (including personal health information and financial information) by SABI Mind, and its authorized agents and service providers as explained. I understand that my personal information will be collected, used and disclosed for purposes relating to the assessment of my eligibility to participate in the Equity Access Program (the "Program") and for the management and administration of the Program, including the provision of the Program services to me, should I be judged eligible to participate, and provision of information about the Program to me. I understand that in order to verify my annual gross income, I may be required to provide a copy of the initial Notice of Assessment received from the Canada Revenue Agency for the most recent year for myself.

I understand that SABI Mind Inc has a legal obligation to report adverse events relating to its services and to monitor service complaints. Personal information provided to the Program may be (i) monitored by SABI Mind Inc or its service providers for safety-related data and service complaints in order to ensure compliance with these legal reporting requirements, and (ii) reported to local or international health authorities. SABI Mind Inc may contact you or your physician for additional information to fulfill its reporting obligations. Your personal information may be combined with the information of others who participate in the Program in order to generate aggregated data that does not contain identifying information ("Aggregated Data"). Aggregated Data may be used by SABI Mind Inc and its service providers to improve and/ or refine the Program to design and implement other

patient programs and for research purposes including the identification of trends such as product utilization, adherence or outcomes.

Please note that SABI Mind and its service providers may store or process your personal information in Canada. In addition, your personal information may be used or disclosed to third parties when permitted or required by applicable laws, court orders or government regulations (collectively, “Applicable Laws”).

Your personal information will be retained only for as long as is needed to fulfill the purposes for which it was collected and in order to comply with Applicable Laws. Industry-standard safeguards will be used to protect the security of the personal information that is collected. You may contact SABI Mind at any time to update or access your personal information, modify or withdraw your consent (in part or in full), express a privacy-related concern, or inquire about the privacy practices of the Program (including those related to foreign information processing).

You can reach us at hello@sabimind.com. Please note that if you modify or withdraw your consent, your ability to receive the Program services may be limited.

Please submit completed applications to hello@sabimind.com with the subject line, EAP Application.

Patient Signature: _____ **Date: _____**