[BIOMATRIX]
Specialty Infusion Pharmacy

Patient Agreement and Acknowledgment ("Agreement")

Patient Name: (Subject)_____Parent/Guardian/Authorized Agent:_____

Patient Date of Birth:_____Address:_____ Phone Number:_____

1. Consent to Receive Services and Acknowledgments: I understand I have the right to choose the pharmacy I use to receive my prescriptions and professional services. I agree to the provision of products and/or services, which may include pharmacy and nursing services, to me by BioMatrix Specialty Pharmacy, LLC, including any subsidiary, division or affiliated business units under common control or ownership, including without limitation, FFP, LLC dba BioMatrix Specialty Pharmacy FL; FFP Acquisition II, LLC dba BioMatrix Specialty Pharmacy TN; BiologicTx, LLC dba BioMatrix Specialty Pharmacy NJ; Injectable Therapy Services, Inc. dba BioMatrix Specialty Pharmacy CA; K&K Rx Services, LP dba BioMatrix Specialty Pharmacy PA; Decillion Healthcare, LLC dba BioMatrix Pharmacy OH; and Infucare, Ltd., collectively ""Pharmacy"). You authorize Pharmacy to work with your other health care providers while providing services to you.

I acknowledge that:

- I have received a copy of the patient handouts that contain Patient Rights and Responsibilities, DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Supplier Standards, and Emergency Information. I have received the product monograph and instructions to follow up with the Pharmacy if needed. I have had the opportunity to ask any questions that I have regarding these documents and the services that I will be receiving in general.
- I understand that state law prohibits reuse or resale of prescription items once they are dispensed. Therefore, products cannot be returned for credit.
- I understand that I may lodge a complaint without concern for retaliation, reprisal, discrimination, or un-reasonable interruption of service.
- I understand that it is my responsibility to use the products furnished as prescribed by my physician and to contact the Pharmacy or my physician with any questions.
- I understand that it is my responsibility to inform the Pharmacy of any changes to my personal information such as address, phone number, etc.
- I understand I am required to notify the Pharmacy if there are any changes to my insurance such as termination of coverage, change of benefits, change of payer, or any notifications I receive regarding non-payment of claims.

2. Notice of Privacy Practices Acknowledgement: I acknowledge that I have received a copy of the Notice of Privacy Practices outlining the possible uses and disclosures of my private health information or "PHI" and privacy rights. I can review the NPP at any time by visiting: https://www.biomatrixsprx.com/about/new-patient-welcome-packet

3. Assignment of Benefits: I hereby assign and transfer to Pharmacy any and all rights to receive payment of insurance benefits. The assignment of benefits includes pharmaceuticals, durable medical equipment, home health care, nursing and other benefits which are otherwise payable to me for products or services provided by Pharmacy. This assignment covers all benefits under Medicare, other state and federal government-sponsored programs, private insurance and any other health plans. I understand this document constitutes a legal binding assignment and is not a mere authorization to collect benefits on my behalf. I authorize and direct my insurance carrier(s) or payor to furnish an agent of Pharmacy any and all information pertaining to my insurance benefits and the status of claims submitted by Pharmacy. I understand payments may be sent by my insurance provider directly to me; however, I agree that when I receive such payments I will promptly submit them to Pharmacy for payment of my bill.

4. Financial Responsibility. I understand that my insurance coverage may only cover a portion of the total bill or no coverage may exist. I further understand that I am responsible for all charges not covered or denied, whether services were rendered before or are rendered after the date this Agreement was signed. I agree that if a claim is denied I will take full responsibility for the submitted charges. If I fail to take responsibility for such charges or fail to remit payment as I have agreed, any amounts due and owing to Pharmacy may be turned over to a collection agency. I understand and agree that I may also be subject to a finance charge of 18% per year or the maximum amount allowed by applicable law, whichever is lower; legal fees; and any other fee(s) incurred attempting to collect such payment. I authorize, designate, and assign to Pharmacy as my (or the Patient's) personal representative to pursue all claims arising under State and Federal law (including claims arising under the Employee Retirement Income Security Act of 1974 (ERISA)) and further assign all rights and privileges afforded under my (or the Patient's) health benefit plan regardless of the payor source. I understand that this assignment of rights, benefits and claims does not relieve me (or the Patient) of my obligations to pay Pharmacy for any charges not covered by this assignment or not paid by insurance or health care benefits. I understand and acknowledge that whether I sign as a representative or am the Patient, I am responsible for and guarantee payment of any charges incurred for medications, supplies or services provided by Pharmacy. I authorize Pharmacy and its assignees to order a consumer credit report from one or more consumer credit reporting agencies and verify other credit information. Pharmacy and its assignees may use the credit report for any purpose that would be authorized by applicable law in connection with any charges I incur, including without limitation (i) for authenticating my identity; and (ii) to make credit decisions. I understand that if my balance becomes seriously past due, Pharmacy may have to take action to assist in the management of my account. This includes using a collection agency and possibly the termination of services. Pharmacy is sensitive to my needs and the increasing cost of prescription medications. Pharmacy encourages me to contact one of its Collection Specialists if I am experiencing payment problems at 877-337-3002, option 5.

I also acknowledge:

- I agree to participate and assist Pharmacy and its designated representatives with any administrative appeal and/or litigation process necessary to exercise the rights granted herein, including but not limited to collection of payment for treatment and services rendered from any third-party payor.
- I appoint Pharmacy with a limited power of attorney to act as my representative and on my behalf in any proceeding that may be necessary to assert my rights including, but not limited to, seeking payment from, or against any third party Payor arising under State or Federal law (including an ERISA claim) relating to all medical treatment and that I (or the Patient) have or will receive from the Pharmacy.
- Should there be an overpayment on my account, a refund check will be mailed to the payor that submitted the overpayment.
- Pharmacy shall be entitled to the full amount of its charges without offset or reduction.
- I understand and agree this authorization will have continuing effect from my (or the Patient's) initial medical treatment for so long as I am being treated or cared for by the Pharmacy and will constitute a continuing authorization, maintained on file with the Pharmacy, which will authorize and allow for direct payment to the Pharmacy of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, or supplies and/or care provided to me by the Pharmacy and grant all such further rights as provided herein.

• A copy of this authorization will be sent to the Centers for Medicare and Medicaid Services, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by the Pharmacy.

5. Form of Payment: Payment of deductibles, copayments and coinsurance is due at the time the services are rendered unless other arrangements are made in advance. The Pharmacy accepts cash, checks, Visa, MasterCard, American Express, debit cards and direct bank drafts. There will be a service charge for all returned checks of $25.00. If the amount of the check plus the service charge is not paid within 30 days of receipt of notification, your account will be subject to additional collection fees, subject to state allowable interest rates and or penalties.

6. Lost or Damaged Shipments: Notification of all claims for a lost or damaged shipment must be made to the Pharmacy within one business day of the shipping date and/or receipt of delivery. Original shipping carton and contents of a damaged shipment must be retained for inspection.

7. Indemnification: Patient agrees to indemnify the Pharmacy for any costs, finance charges, collection cost, legal fees, filling fees, court cost, including attorneys' fees, and credit reporting fees which the Pharmacy incurs in pursuant of collection from the Patient because of default of its obligations described in this Agreement.

8. Choice of Law; Venue; and Personal Jurisdiction: To the extent permitted by state or federal laws, this Agreement, its validity, performance, and all other disputes arising hereunder shall be governed and determined by the laws of the State of Florida, excluding its conflict of law's provisions. I irrevocably consent to the jurisdiction of any court of competent jurisdiction in Broward County, Florida as the forum for resolution of any claims or actions arising out of or relating to this Agreement or the products and services described herein, and hereby waive objections to venue in such a court, to the defense of an inconvenient forum in such court, and to the defense of lack of personal jurisdiction of such court unless, at the Pharmacy's option, it chooses to pursue legal remedies in the court of competent jurisdiction and venue in the state and county the Patient is residing or has received services from the Pharmacy. **The Pharmacy's goal is to provide pharmaceutical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.**

9. CMS Medicare DMEPOS Supplier Standards: If applicable, I acknowledge receipt of the Medicare Supplier Standards and was given an opportunity to ask questions and voice concerns. I have been advised that I may rent or purchase inexpensive or routinely purchased durable medical equipment, and the purchase option for capped rental equipment (where Medicare will pay a monthly rental fee for a period not to exceed 13 months after which ownership of the equipment is transferred to the Medicare beneficiary. After ownership of equipment is transferred to a Medicare beneficiary, it is my responsibility to arrange for any required equipment service or repair.) As a Medicare beneficiary (if applicable) I have been notified of warranty coverage. The Pharmacy will honor all warranties under applicable State law, and repair or replace free of charge Medicare covered equipment that is under warranty.

10. Educational Material: I acknowledge receipt of educational materials, which have been explained, and all equipment, medication, and supplies provided by the Pharmacy. If applicable, a home safety assessment was conducted during the admission process and applicable safety precautions materials were given to me.

11. Pharmacy Consultation: I understand a pharmacist may be contacting me to discuss my drug therapy. I further understand that a pharmacist familiar with my therapy services is available to me 24 hours a day if I have any questions and can be reached by calling the phone number on the enclosed pharmacy contact sheet.

I have questions about my drug therapy or request a pharmacy consultation. ☐ **No** ☐ **Yes**

12. After Hours/Emergency Information: I understand that I should call 911 for all medical emergencies. I was told how to contact the Pharmacy after hours if I have questions regarding my prescription.

13. Advance Directives: An advance directive is your way of letting health care providers and your family know your decisions about healthcare and the right to accept or refuse services. I understand that the Federal Patient Self-Discrimination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak to myself. If you have an Advance Directive, please provide it to the Pharmacy.

14. TCPA Consent & Privacy: By providing my telephone number and signature below, I authorize Pharmacy and its agents, representatives, affiliates, or others calling on Pharmacy's behalf to deliver or cause to be delivered to the number I entered above telephonic sales calls, voice messages and text messages. This includes the use an automated system for the selection and dialing of telephone numbers, automated voice calls, or the playing of a recorded message when connection is completed to my number, or the transmission of prerecorded voicemails. These calls and messages may concern my prescription, including reminders, billing, shipping, logistics, patient satisfaction, and other pharmacy related messages, and other information related to my health, which may include telephonic sales calls or messages. I further consent to automated or prerecorded messages being played when the telephone is answered whether by me or someone else. Telephone calls may be monitored or recorded for quality and other purposes. Consent to such calls and text messages is not a condition of receipt of services. I further understand standard message and data rates apply to such calls and messages. I agree to promptly alert Pharmacy whenever I stop using a particular telephone number. Reply STOP to opt out of text messaging. I am not required to directly or indirectly sign this written agreement or to agree to enter into such an agreement as a condition of purchasing any property, goods, or services.

15. Health Information Exchange. Pharmacy participates in CommonWell Health Alliance, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that your providers have real-time access to your information. I authorize Pharmacy to share my information, including my healthcare and personal information with CommonWell Health Alliance for the purpose of enabling my healthcare providers to provide care and/or treatment to me. You can opt-out of this at any time by contacting Pharmacy in writing at privacy@biomatrixsprx.com.

16. E-mail. I want to receive communications via e-mail from Pharmacy. By providing my email address I (1) consent to Pharmacy sending me communications by email that may contain protected health information, and (2) acknowledge and accept that email communications are not secure and there is a risk that they may be intercepted or viewed by unauthorized parties.

By signing below, I certify that I am the patient, guardian, or authorized representative for the patient, Pharmacy has provided me with the above disclosures and I agree and consent to receive services from Pharmacy in accordance with the terms in this Agreement.

Signature of Patient (if over 18 years of age) or Legal Representative* Date signed

Print Patient or Legal Representative Name

Relationship of Representative to Patient:_____

Is Patient a Minor? ☐ Yes ☐ No

[BIOMATRIX]
Specialty Infusion Pharmacy

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR MARKETING

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. We must obtain your special authorization before we may disclose your protected health information for the purpose described below.

I, the undersigned, authorize BioMatrix Specialty Pharmacy, LLC, along with its subsidiaries and affiliates, including but not limited to FFP, LLC dba BioMatrix Specialty Pharmacy FL; FFP Acquisition II, LLC dba BioMatrix Specialty Pharmacy TN; BiologicTx, LLC; BioMatrix Specialty Pharmacy NJ, K&K Rx Services, LP dba BioMatrix Specialty Pharmacy PA, Decillion Healthcare, LLC dba BioMatrix Specialty Pharmacy OH; Injectable Therapy Services, Inc. dba BioMatrix Specialty Pharmacy CA, and Infucare LTD (herein referred to as "the Pharmacy), to use and disclose my health information, including protected health information ("health information"), for the purpose identified below as required by the Health Insurance Portability and Accountability Act ("HIPAA") and other state and federal privacy laws.

INFORMATION TO BE USED AND DISCLOSED, RECIPIENT AND PURPOSE

I authorize Pharmacy to use and disclose my prescription information, contact information, personally identifiable information, medical expense summaries, prescription claims information, financial information regarding my services, and information within a Designated Record Set (entire medical record maintained by the Pharmacy) for the purpose of marketing for which Pharmacy may receive direct or indirect payment from a third-party.

EXPIRATION OF AUTHORIZATION

My authorization to permit the use or disclosure of my health information will be effective on the date of signature, below and will expire one year from the date of my last receipt of services from Pharmacy, unless an earlier termination is required by law.

- I understand that signing this form is voluntary and I have the right to revoke this authorization, except to the extent Pharmacy has already used or disclosed by health information in reliance of this authorization. I understand that I may revoke my authorization at any time by giving ***written notice*** of my revocation to the Pharmacy at ATTN: Privacy Officer, 855 SW 78th Ave, #C200; Plantation, FL 33324.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization.
- I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my health information and may no longer be protected by state or federal privacy regulations.
- I will be provided with a copy of this authorization upon request. I may request a copy of this authorization by [insert process (e.g., submitting the request in writing to the Pharmacy ATTN; Privacy Officer, 855 SW 78th Ave, #C200; Plantation, FL 33324.

Signature of Patient (if over 18 years of age) or Legal Representative*	Date	Print Patient or Legal Representative Name

Legal Authority: Select one ☐ parent ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care