Memorial Specialty Pharmacy

Service Agreement and Assignment of Benefits

In exchange for Memorial Specialty Pharmacy Services agreement to (i) provide me with my medications; and (ii) bill my insurance carrier or third-party payer that is obligated to pay for my medications, I agree to the following terms and conditions;

1. AUTHORIZATION FOR MEDICAL TREATMENT: I authorize Memorial Specialty Pharmacy Services under the direction of my physician, to provide my medications to me. I have been instructed by my physician about my prescribed medications and understand the reasons why they are considered necessary, their risks, advantages, possible complications and alternatives. As in any medication therapy, I understand that there are unknown risks as well as risks. I certify that no guarantee or promise, expressed or implied, has been made to me in conjunction with the medications that have been prescribed for me.

2. RELEASE OF INFORMATION: I understand that Memorial Specialty Pharmacy Services will use my protected health information ("PHI") in accordance with the Memorial Healthcare System Privacy Notice (the "MHS Privacy Notice") that I have received from Memorial Specialty Pharmacy Services. If I have not received the MHS Privacy Notice, I agree to call 954-276-6779 to request another copy from Memorial Specialty Pharmacy Services.

3. ASSIGNMENT OF BENEFITS: I hereby assign to Memorial Specialty Pharmacy Services all insurance benefits and payments to which I am entitled from all third-party payors that are obligated to pay for my medications (including Medicare and/or Medicaid if applicable), for and services, medications, equipment or supplies which are furnished to me by Memorial Specialty Pharmacy Services. I also authorize Memorial Specialty Pharmacy Services to seek such insurance benefits and payments from all third-party payors that are obligated to pay for my medications directly and that this assignment of benefits shall be ongoing and continuous, unless and until cancelled by me in writing. Cancellation of this assignment of benefits shall become effective when the cancellation is delivered to Memorial Specialty Pharmacy Services, my insurer(s) and each third-party payor that is obligated to pay for my medications. I request that payment of authorized benefits be made directly to Memorial Specialty Pharmacy Services on my behalf for any medications furnished to me by Memorial Specialty Pharmacy Services.

4. FINANCIAL RESPONSIBILITY: I understand and agree that I am responsible for the payment of any and all sums that may become due for the medications provided to me by Memorial Specialty Pharmacy Services. If, for any reason and to whatever extent, Memorial Specialty Pharmacy Services does not receive payment from my insurer or the third-party payor that is obligated to pay for my medications, I do hereby agree to pay Memorial Specialty Pharmacy Services directly for the unpaid balance within thirty (30) days of receipt of an invoice from Memorial Specialty Pharmacy Services, except in cases where such payment to Memorial Specialty Pharmacy Services is prohibited by applicable law. If my insurer and/or third-party payor that is obligated to pay for my medications issues payment directly to me, I agree to promptly endorse such payment to Memorial Specialty Pharmacy Services and forward it directly to Memorial Specialty Pharmacy Services on the day that I receive payment.

5. UNPAID INVOICES: I agree that any amounts I owe to Memorial Specialty Pharmacy Services for more than thirty (30) calendar days shall bear interest from the due date of such invoice, at the lesser of, one and one-half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs and expenses of Memorial Specialty Pharmacy Services collection efforts, including reasonable attorney's fees and court costs that are incurred by Memorial Specialty Pharmacy Services to collect overdue amounts.

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6. ENTIRE AGREEMENT: This agreement contains the entire agreement of the parties. No other representation, promise, or agreement, oral or otherwise, expressed or implied, not embodied herein, shall be of any force or effect. All amendments must be in writing and signed by both parties to have any effect. This Agreement shall be binding upon and insure to the benefit of the parties hereto and their respective successors, heirs and assigns.

7. RETURN MEDICATION PROCEDURE: All unused portions of any patient's discontinued prescription medication shall be immediately isolated. Non-controlled medication shall be destroyed or returned to the pharmacist or provider pharmacy supplying pharmaceutical services within 72 hours with the appropriate notation of disposition. The notation shall include the date, quantity and name and strength of the medication. Medications for hospitalized patients must be isolated and may be held until the patient's return or permanent discharge. Destruction of discontinued controlled patient medication and discharged or deceased patient's controlled medication shall be jointly performed by two authorized licensed personnel within 72 hours of the discontinuation of the medication or discharge of the patient. A record of the destruction must be signed by both parties and kept at the facility for 2 years.

I have read, understood and agreed to all of the above. A photocopy of this agreement may be used as though it were an original. This Service Agreement and Assignment of Benefits will be effective until revoked by me in writing. Such revocation shall have a prospective effect only.

Print Patient Name

Patient/Guardian Signature Date:

Signature of the Primary Insured Date: