Instructions to Patient or Legal Representative:

- Please sign this agreement and return it to Star Discount Pharmacy at the address above.
- Please acknowledge your desire for easy-open caps completing the Safety Cap waiver section.
- Make a copy of this signed document for your records.

Provision of Services

I understand that by signing this agreement, I certify my wish to be enrolled in the Star Discount Pharmacy. I understand that by enrolling with these specialty services, I will be eligible to receive additional services such as the following: patient education face-to-face, by phone or via mail; phone calls, or other mechanisms, reminding me to refill my medication as prescribed by my physician; assistance with reimbursement issues and patient co-insurance where applicable; and educational phone calls and mailings relating to my condition or drug therapy. If at any time, you would like to opt out of the Star Discount Pharmacy Specialty Program, you may contact us.

Financial Responsibility Notice

I understand and agree to be responsible for the payment of any and all sums that may become due for the pharmacy and patient care services provided to me by Star Discount Pharmacy. If, for whatever reason and to whatever extent, Star Discount Pharmacy does not receive payment from my insurance carrier, I do hereby agree to pay Star Discount Pharmacy the balance in full for any amounts due within thirty (30) days from the date of the invoice. In the event that I do not pay my balance in full within the time period set forth in the invoice, I hereby agree to pay the late payment service charge indicated on the invoice. If Medicare or my other insurance company denies payment, I will be notified by receipt of a billing statement for all denied services. I understand that as the insured, I will be fully responsible for payment for all denied services.

Patient Support Programs

I authorize Star Discount Pharmacy to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training or financial assistance. I further authorize Star Discount Pharmacy to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) for the purpose to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand that I may revoke this authorization at any time, in writing by sending a letter to Star Discount Pharmacy at 704 Pratt Ave NE, Huntsville, AL 35801. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

Child Resistant Packaging

I understand that some products and medications are not available in a child resistant package. I will accept full responsibility for the use of all my medications and understand that Star Discount Pharmacy cannot be held liable for the misuse or accidental use of any medications regardless of packaging.

Authorization to Leave Messages

I authorize and allow phone and/or text messages regarding my prescription and care services can be left at the phone number(s) on file and given to Star Discount Pharmacy by myself or caregiver.

Release of Information

I authorize all health care providers, insurers, or other parties with health care information about me to release to Star Discount Pharmacy any and all of my health care records, including prescription records, that are related to, or may assist, in the treatment

of the condition(s) for which Star Discount Pharmacy is providing services to me (hereafter referred to as "My Records"). I authorize Star Discount Pharmacy to use information from my records for purposes related to my treatment, including utilization review, quality management, analysis activities, as well as to establish my eligibility for benefits payable by my insurer. I further authorize Star Discount Pharmacy to release any and all information from my records as may be necessary for Star Discount Pharmacy to receive payment or benefits on my behalf, to communicate as necessary with my other health care providers regarding services provided to me by Star Discount Pharmacy, and to comply with audit requests of accrediting bodies or government agencies. I understand that Star Discount Pharmacy may use information from my records that does not identify me personally for data collection, statistical analysis and other purposes undertaken in normal course of business. I hereby release, on my behalf and on behalf of my successors and assignees, Star Discount Pharmacy and their officers, directors, employees and agents from any and all liability from the release of my records and from the use of information released from my records as described above.

Notice of Health Information Practices

By signing below, I state that I have received a copy of the Star Discount Pharmacy Notice of Privacy Practices, and that I can obtain a copy of the Notice of Privacy Practices, regarding the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") from Star Discount Pharmacy at any time.

Authorization Signature(s) for Patient Agreement

By signing below, I certify that I have read and accepted the terms of this Patient Agreement and that I received a copy. I also certify that I am the patient, or that I am duly authorized by the patient as the patient's agent, to accept and sign this Patient Agreement on behalf of the patient.

Patient/Spouse/Patient's Agent Electronic Signature Relationship to Patient Date

Patient Name Patient Date of Birth

Patient Declined to Sign. Patient agrees to electronic signature. Yes No Date

Authorization to Speak on My Behalf

I hereby authorize the following person(s) to speak on my behalf regarding my prescription services, care and delivery.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Safety Cap Waiver Notice

I authorize the use of non-child-resistance caps on my prescriptions (where possible). ☐ Yes ☐ No

I confirm that the information provided above is accurate and complete to my best understanding.

Patient Signature:_____ Date:_____