Patient Acknowledgment and Informed Consent to Treatment

Patient Name _____ Date of Birth _____

CONSENT FOR TREATMENT

I hereby authorize BriovaRx® Specialty Pharmacy ("BriovaRx") to provide products, supplies and services as prescribed by my physician. I confirm I have been informed and have participated in planning my care and sign this consent willingly and voluntarily. I understand this consent is valid from the date of the start of initial therapy and I may withdraw my consent at any time by notice to BriovaRx and, if I do so, the services thereafter will not be provided.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and transfer to BriovaRx any and all rights to receive payment of insurance benefits. The assignment of benefits includes pharmaceuticals, durable medical equipment and, if applicable, home health care, nursing and surgical benefits which are otherwise payable to me for products or services provided. This assignment covers all benefits under Medicare, other state/federal government-sponsored programs, private insurance and any other health plans.

I understand this document constitutes a legally binding assignment, and is not a mere authorization to collect benefits on my behalf. I also authorize and direct my insurance carrier(s) to furnish an agent of BriovaRx any and all information pertaining to my insurance benefits and the status of claims submitted by BriovaRx for services rendered. I understand payments may be sent by my insurance provider directly to me. I agree when such payments are received, I will promptly submit them to BriovaRx for payment of my bill. I can make payment by personal check or endorsement of the insurance payment by writing "Pay to the order of BriovaRx" and my signature. I understand I am also responsible for co-payments, deductibles and services not otherwise covered by my insurance carrier.

PAYMENT OF SERVICES RENDERED

I understand I am the responsible party for all medications and services rendered by BriovaRx. I understand it is my responsibility to notify BriovaRx of my insurance information, including prescription card information.

I understand it is my responsibility to notify BriovaRx of any changes in my insurance coverage.

I understand it is my responsibility to pay for any medications and services rendered which are not covered or are rejected by my insurance carrier, for whatever stated reason.

BriovaRx will provide products and / or services agreed upon at order coordination to the stated patient. The estimated cost of each treatment will be communicated at time of order coordination.

I understand the amount may vary depending on deductible and out-of-pocket expenses. I agree to make payment arrangements at the time of order coordination.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices concerning Protected Health Information (PHI) from BriovaRx.

ACKNOWLEDGMENT OF RECEIPT OF MANDATED FORMS

I hereby acknowledge receipt of Client Bill of Rights, receipt of medication refill and shipment process, receipt of infection control procedures and receipt of procedure for filing a grievance or complaint.

I hereby acknowledge receipt of the DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) Supplier Standards and Medicare Prescription Drug Coverage and Rights as a Medicare beneficiary. (Patients not covered by Medicare will not receive these notices.)

PRODUCT WARRANTY/REPLACEMENT INFORMATION

BriovaRx will honor all express warranties under applicable State Law. BriovaRx will not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items that are covered under warranty. This applies to all purchase items. Please notify BriovaRx at 855-427-4682 for any product that is broken, damaged, or does not properly function.

I have been instructed and understand the warranty/replacement information on the product I have received.

I agree to the terms stated in the BriovaRx Patient Acknowledgment and Informed Consent to Treatment

PATIENT SIGNATURE (or Representative): _____ Date Signed: _____

Relationship of Representative to Patient: _____ Is Patient a Minor? ○Yes ○No

SIGN AND RETURN THIS DOCUMENT TO:

BriovaRx, 1050 Patrol Road, Jeffersonville, IN 47130

IMPORTANT

Please sign and return