Diplomat
Specialty Pharmacy

Enroll In Our Free Health Management Program

Choose one of four ways to enroll in our Free Health Management Programs:

- **Telephone:** Call Diplomat Specialty Pharmacy Toll Free at: 1.877.977.9118
- **Online:** Enroll at diplomatpharmacy.com
- **Fax** all pages of this form to: 1.800.550.6272
- **Mail** this form to: Diplomat Specialty Pharmacy 4100 S Saginaw Flint, MI 48507

Patient Information

Name (last,first, mi)____

Social Security No.________________________ Date of Birth______________________________

Phone (   )________________________ Best Time To Call__________________________

Address____

City_____________________________________ State________Zip____________

Spouse Name/Parent(s)/Other____

Diagnosis____

Allergies (drug/other)____

Current Medications____

Insurance Information

Primary Insurer____

Name of Policy Holder____

Social Security No.______________________________Date of Birth________________

Policy#___________________________________Group#_______________________

Rx Card___________________________________ Card#_______________________

Phone (   )____

HealthCare Provider

Physician____

Phone (   )____

Case Manager ____

Phone (   )____

Please Sign Patient Agreement on Next Pages

Patient Agreement

Request for Provision of Services

I understand that by signing this agreement, I indicate my wish to enroll in the Diplomat Specialty Pharmacy program. I understand that by enrolling in the program, I will receive some or all of the following services from Diplomat Specialty Pharmacy. This includes: periodic phone calls and/or letters for the purpose of reminding me to refill my medication as prescribed by my physician; assistance with reimbursement issues; and educational phone calls and mailings relating to my condition.

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 Diplomat Specialty Pharmacy can not be held liable for the misuse or accidental use of any medications regardless of packaging.

Financial Responsibility

I understand and agree to be responsible for the payment of any and all sums that may become due for the pharmacy-related care provided to me by Diplomat Specialty Pharmacy. If, for whatever reason and to whatever extent, Diplomat Specialty Pharmacy does not receive payment from my insurance carrier, I do hereby agree to pay Diplomat Specialty Pharmacy for the balance in full for any amounts due within fifteen (15) days from the date of the invoice. In the event I do not pay my balance in full within the time period set forth in the invoice, I hereby agree to pay a late payment service charge in the amount of 1.25% a month (18% annually or the maximum rate permitted by law, whichever is lower). Medicare will only pay for services it determines to be "Reasonable and Necessary." 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 of all denied services.

Release of Information

I authorize all health care providers, insurers, or other parties with health care information about me to release to Diplomat Specialty 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 Diplomat Specialty Pharmacy is providing services to me (hereafter referred to as "My Records"). I authorize Diplomat Specialty 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 Diplomat Specialty Pharmacy to release any and all information from My Records as may be necessary for Diplomat Specialty 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 Diplomat Specialty Pharmacy, and to comply with audit requests of accrediting bodies or government agencies. I understand that Diplomat Specialty Pharmacy may use information from My Records that does not identify me personally for data collection, statistical analysis, and other purposes undertaken in Diplomat Specialty Pharmacy's normal course of business. I hereby release, on my behalf and on behalf of my successors and assigns, Diplomat Specialty Pharmacy and its officers, directors, employees and agents from any and all liability arising from the release of My Records and from the use of information released from My Records as described above.

Patient Support Program Agreement

I authorize Diplomat Specialty 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. I further authorized Diplomat to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) 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 I may revoke this authorization at anytime in writing by sending a letter to Diplomat Pharmacy, 4100 S Saginaw .Flint, MI 48507.

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.

Continued on back

Patient Agreement - continued

Authorization To Speak On My Behalf

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

Name Relationship

Name Relationship

Authorization To Leave Messages

I hereby authorize that phone messages and/or text messages are allowed to be left at the below number(s) regarding my prescription services, refills, renewal and delivery.

Phone Number Alternate Phone Number

Notice of Health Information Practices

By signing below, I state that I can obtain a copy of Diplomat's Notice of Health Information Privacy Practices, regarding the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") from Diplomat Specialty Pharmacy at anytime.

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/Guarantor/Guardian Signature Relationship to Patient Date

PLEASE PRINT PATIENT NAME

NOTE: A duplicate copy of this Patient Agreement shall be considered the same as the original