RELEASE OF INFORMATION

Please complete and return the attached "AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA" form. Thank you!

Financial Responsibility and Assignment of Benefits

Medford Chemists Inc. agrees to bill Medicare, Medicaid or a private insurance carrier for any pharmaceuticals dispensed. Should it be required by any program that the client is responsible for any deductible, co-insurance, co-payment or disallowance of payment, Medford Chemists Inc. has the right to bill the client of those charges, provide an accurate as possible estimate of the charges billed to the payer and of those, if any, which will be billed to the client. Further notification is provided that the cost(s) of services may have to be negotiated with your insurance company after delivery is made and that a good will estimate can be provided upon request. I, at this moment authorize Medford Chemists Inc. to request any medical records or copy of such that may be needed to ensure accurate costs of goods/services.

I agree that the insurance company's verification of benefits does not release me from financial responsibility for services rendered. If the insurance company denies any claims, in part or whole, I am financially responsible for all charges not covered by my insurance. I understand that the insurance claims are subject to medical review and that the insurance company is not obligated to pay for services not covered by the applicable policy. I understand that this notification of benefits is a good faith estimate and that actual client financial responsibility will be determined when the claim is processed.

Payment Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Medford Chemists Inc. for any services furnished to me by Medford Chemists Inc. I authorize any holder of medical information to release information about me to Medford Chemists Inc. and its agents, including information needed to determine these benefits.

I agree to inform Medford Chemists Inc. Corp. of any change in my status including, but not limited to; change in address, hospital or nursing home admissions and discharges, and any changes that affect my insurance coverage and payments or my ability to pay for products and services rendered by Medford Chemists Inc. If you have any questions regarding this form, please contact Medford Chemists Inc.

_____ Date:_____

Client/Representative Signature

_____ Relationship: _____

Print Client/Representative Name