Service Agreement

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

1. **Authorization for Medical Treatment:**
   I authorize Publix Specialty Pharmacy, 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 known and unknown 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 Publix Specialty Pharmacy will use my protected health information ("PHI") in accordance with the Publix Specialty Pharmacy Notice of Privacy Practices that I have received under separate cover from Publix Specialty Pharmacy. If I have not received a Publix Specialty Pharmacy Notice of Privacy Practices, I agree to call **1.855.797.8254** to request a copy from Publix Specialty Pharmacy.

3. **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 Publix Specialty Pharmacy. Payment may include out-of-pocket costs, such as deductibles, co-pays, and co-insurance. If we are not a network pharmacy with your plan, we will let you know how this affects the cost of your prescription. If, for any reason and to whatever extent, Publix Specialty Pharmacy 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 Publix Specialty Pharmacy directly for the unpaid balance within thirty (30) days of receipt of an invoice from Publix Specialty Pharmacy, except in cases where such payment to Publix Specialty Pharmacy 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 promptly to endorse such payment to Publix Specialty Pharmacy and forward it directly to Publix Specialty Pharmacy on the day that I receive payment.

4. **Consent to Contact:**
   By providing my contact information and signing below, I authorize Publix or its affiliates to contact me at the mobile number and email address provided and to deliver unencrypted messages or calls using an automated dialer, an artificial or pre-recorded voice, or other means, for any and all purposes related to Publix's pharmacy services and my enrollment and treatment, including related to appointment reminders, payment, insurance, healthcare operations, quality improvement, case management, utilization, or for advertising care alternatives and other benefits, products, and services that may be of interest. I understand that the messages are not secure. If others intercept the messages or access my device, they will be able to see confidential health information. I understand that I need not agree as a condition to purchase any goods or services.

5. **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.

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

Patient Name (Please print)

Mobile Phone

Email Address

Patient/Guardian Signature Date

Signature of the Primary Insured Date

Pharmacy