PLEASE PRINT VERY CLEARLY

Line items printed in bold on this page are required fields, if they apply. Thank you for your assistance.

☐ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ Soc. Sec. # _____ Home Phone _____ Email address _____ Cell Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex: _____

Race: ☐ Black / African American ☐ White / Caucasian ☐ Hawaiian / Pacific Islander ☐ American Indian ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other / Prefer not to specify Note: Race and Ethnicity answers are optional.

How did you hear about Noble Infusion Services?

_____

☐ Primary Insurance

If you have accident, no-fault or workers comp, make a check mark in this box: ☐

Insurance Company _____

Insurance ID # _____ Group # _____

Policyholder's Name (Last, First, Middle)

_____

Relationship to Patient _____ Policyholder's SSN # _____ Policyholder's Birthdate _____

☐ Secondary Insurance

Insurance Company _____

Insurance ID # _____ Group # _____

Policyholder's Name (Last, First, Middle)

_____

Relationship to Patient _____ Policyholder's SSN # _____ Policyholder's Birthdate _____

☐ Pharmacy Benefit Insurance

Insurance Company _____

ID # _____ Group # _____ BIN # _____ PCN # _____

□ Assignment and Release

I hereby authorize payment directly to Noble Infusion Services LLC and/or its affiliates, partners and licensees (including, without limitation, Noble Infusion Medicine PC and Our Medical Director) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me. I authorize the providers, staff and billing agents of this practice to release any information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. Should any insurer, vendor or provider require acknowledgement of receipt for any services, therapies and/or products, the signature on this page suffices and can be applied by you to those acknowledgements.

Signature: _____ Date: _____ Patient Name: _____

Date of Birth: _____

□ Emergency Contact

In the event a medical emergency arises, or you need to be transported from our center to an emergency room or other medical treatment facility, please provide us with an emergency contact person.

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

□ Present Medical Condition

What is the underlying medical condition and the medication for which you are seeing injection or infusion treatment with Noble Infusion?

_____

_

Which medical provider ordered the infusion or injection treatment?

_____

_

Please list your other current medical providers who are relevant to the underlying condition for which you are seeking treatment.

Provider Name: _____ Phone: _____ Specialty: _____

Provider Name: _____ Phone: _____

Specialty:_____ Provider Name: _____ Phone:

_____ Specialty: _____

□ Medical History

Which surgical procedures have you had, and when did you have them?

_____ _

What current health conditions do you have, other than the underlying medical condition you listed above?

_____

_ Please list any other chronic and/or ongoing medical conditions that you have:

_____

_ What medications (and dosages, if possible) are you currently taking?

_____

_ If you have any allergies, whether medical, environmental or food related, please list them here:

_____

_

Do you currently smoke? Yes No If yes, what do you smoke? _____
If no, were you ever a smoker? Yes No

Do you currently drink alcohol? Yes No If yes, how many drinks per day? _____
When did you last consume alcohol? _____

If you do not drink alcohol now, did you in the past? Yes No

BILLING and COLLECTION POLICIES

Your rights and responsibilities are outlined here. Please read carefully before signing.

Upon scheduling and registration we require you to provide your medical insurance card(s), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's full address, date of birth, and phone number as well. For collection purposes, we require social security numbers as well. If your insurance coverage or its policyholder information changes at any time, you are responsible for promptly notifying us. Failing to notify us of changes in a timely fashion may limit your rights as far as your insurance claim processing

is concerned, and can result in larger than expected medical bills. Failing to notify us of changes to your insurance coverage, including failure to pay premiums, may constitute fraud, and we may be obliged to report such behavior.

Medicare: If you have coverage with Medicare (either original Medicare, directly from the government, or a Medicare Advantage plan, such as Medicare through a commercial carrier), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a coinsurance. Any portion of this deductible and coinsurance that is not covered by a supplemental carrier will be your financial responsibility to pay. Medicare Advantage beneficiaries may be responsible for a copayment, coinsurance, deductible, or any combination thereof. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare and another insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding this provision. Please note that when single dose vials are used, there is a charge for both the administered medication as well as any wastage as per standard industry practices.

Participating Commercial Insurance: If you have an insurance plan with which we participate, you agree to comply with all the plan's provisions and obligations. You are responsible for paying your copayment, if applicable, at the time of service, as well as payment of any other financial obligations for the visit, including without limitation coinsurance and/or deductible. If your plan advises us at any time that you do not have coverage for any services rendered, or you are not covered for services rendered for any reason, you will be billed for the entire balance. If your plan makes payment directly to the patient or policyholder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to us and submitting it along with a complete copy of the Explanation of Benefits. Should you be issued payment by the insurance carrier and not promptly turn it over to us in whole, legal action will be pursued and you may be discharged as a patient. Bills for any balances applied to the patient's financial obligation are due immediately upon receipt. Please note that when single dose vials are used, there is a charge for both the administered medication as well as any wastage as per standard industry practices. You are hereby made aware that if you change insurance plans or carriers, and your new plan or carrier requires an authorization for your treatment and/or medication, and you do not notify us of this change with sufficient opportunity for us to obtain such authorization, and nonetheless you obtain said therapy from us when we are operating under the understanding that your prior insurance carrier or plan is in force, you will be held wholly responsible for the entirety of the charges for such treatment. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plans may offer you regarding this provision.

Self Pay: Patients without insurance, whose insurance coverage does not cover the services rendered for any reason, who have an insurance carrier or an insurance plan with which we do not participate, or who choose to obtain services outside the scope of their insurance coverage, shall pay for all services rendered in advance of the service. Payment must be made in full in order to secure each appointment. Payment by credit card will include a fee of $3 per $100 or fraction thereof to cover processing charges. You may request a detailed receipt after services are rendered, and one will be sent to you within five (5) business days by our business office. We make absolutely no warranties about what, if anything, your insurance carrier or plan with which we do not participate may reimburse you or cover by your submission of any receipt.

Financial Obligations: It is our right and obligation to bill you for any portion of your treatment that your insurance carrier assigns to your responsibility, and any balance that your carrier does not pay. It is your responsibility, as detailed by the terms

of your health insurance policy, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. If that happens, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. If you bounce a check, you will be responsible for a $50 fee, and will not be able to pay by check again. Failure to show for an injection or infusion, or cancellation on less than 24 hours' notice, constitutes a no-show and is subject to a $150 fee. If you change your mailing address or email address, you are responsible for arranging for forwarding and/or notifying us of the change in a timely fashion – a change of address does not result in a change in the time your payment is due. You may be dismissed as a patient for failure to meet your financial obligations.

Financial Security: It is our policy to request that patients keep a credit card on file as financial security against deductibles, coinsurance and other instances of patient financial responsibility as outlined in this document. If you do not provide a card which is valid when charged, and do not pay your invoices in a timely fashion, we reserve the right to add a 10% penalty for failure to pay to your invoices as a stop-gap against sending accounts to collections and to utilize this card. By providing this credit card information and signing below, you are attesting that you are a duly authorized signer on this account and are wholly authorized to utilize it for these charges. Please provide your credit card information here:

Visa M/C AmEx Card #: _____ Expiration: _____ Security: _____

Credit Card billing address & ZIP code: _____

Credit Card Charges: If you pay for your charges with a credit card and feel the charges are either unwarranted or otherwise not your responsibility based on the provisions of your health insurance plan or regulations, you must first contact our billing department before contacting your credit card vendor. If you contest credit card charges without first contacting us, or you contest charges which your insurance carrier has applied to your financial responsibility, and those charges are reversed by the credit card vendor or merchant bank, your balance due may be immediately treated as overdue debt, a collections fee appended as explained above, and the entire account may be sent to our collection agency.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Noble Infusion Services LLC and/or its affiliates, partners and licensees (including, without limitation, Noble Infusion Medicine PC and Our Medical Director) for any services furnished to me. I understand that the provisions of these policies apply, regardless of any other written or oral assurances made to me by any party, at any time.

Patient Name (Please print clearly): _____

Signature of Patient: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

☐ Noble Infusion Services LLC and its affiliates, partners and licensees (which, throughout this document, includes, without limitation, Noble Infusion and Our Medical Director) may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations ("TPO"). I understand and acknowledge that Noble Infusion Services LLC's Notice of Privacy Practices ("NPP") has a more complete description of such uses and disclosures, and that a copy of that notice is available on its website at www.Noble InfusionIV.com.

☐ I have received a copy of Noble Infusion Services LLC's NPP and/or I have been provided with an opportunity to review it. I understand and acknowledge that Noble Infusion Services LLC reserves the right to revise its NPP at any time, and that a revised version of that notice may be obtained by sending a written request to the Privacy Officer or by visiting the website.

☐ I permit Noble Infusion Services LLC and/or its affiliates, partners and licensees to leave telephone messages regarding my appointments, medications, results and all other PHI, may be left for me on voicemail systems and answering machines, or given to the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

☐ I agree that my PHY may be shared with my spouse (if applicable).

☐ I agree that my PHI may be shared with my other medical providers.

☐ I agree that my PHI may be shared with the following other people:

_____ _____

☐ I agree that Noble Infusion Services LLC and its affiliates, partners and licensees may use my information, including PHI, for operational, discal, promotional and development purposes.

☐ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Noble Infusion Services LLC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Noble Infusion Services LLC and its affiliates, partners and licensees may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

☐ I agree that my PHI may be shared with my credit card vendor(s) to permit Noble Infusion Services LLC and its affiliates, partners and licensees to submit records to support its charges if needed.

☐ I agree that Noble Infusion Services LLC and its affiliates, partners and licensees may contact me at any email address provided to you by me regarding both PHI and non-PHI.

*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")

Patient Name (Please print clearly): _____

Signature of Patient: _____ Date: _____