STATEMENT OF FINANCIAL RESPONSIBILITY

By signing this document, the responsible party accepts the following:

Patient Assignment of Benefits and Appointment of Representation

I, the undersigned, hereby assign all rights and benefits under my health plan, and all rights and obligations that I and my dependents have thereunder, to CND Life Sciences and its authorized representatives for the items and services furnished to me by CND Life Sciences If my health plan fails to abide by my authorization and makes payment directly to me, instead of CND Life Sciences, I agree to endorse the insurance check and forward it to CND Life Sciences immediately upon receipt. I irrevocably designate, authorize, and appoint CND Life Sciences and its authorized representatives as my true and lawful attorney-in-fact for the limited purpose of submitting my claims, obtaining prior authorization and a copy of my health plan document, and pursuing any request, disclosure, appeal, litigation, or other remedies in accordance with the benefits and rights under my health plan in accordance with any federal or state laws. I understand acceptance of insurance by CND Life Sciences does not relieve me from any responsibility concerning payment for such items or services and that I am financially responsible for all charges whether or not they are covered by my health plan. I hereby authorize CND Life Sciences and its authorized representatives to contact me or my health plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to CND Life Sciences in compliance with federal and state laws. CND Life Sciences and its authorized representatives may release to their plan administrator or my health plan, employer, or authorized representative my personal health information for the purpose of precuring payment for laboratory services furnished to me by CND Life Sciences. Rejection of my claim by the insurance carrier does not relieve me of my financial responsibility to CND Life Sciences.

Fees and Payments

Payment in full is required within 30 days of the date the balance is incurred. Payments can be made with personal check, money order, Visa, MasterCard, American Express, or Discover.

PLEASE NOTE: Your medical record and diagnosis is determined by the ordering provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. Requesting a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Notice of Privacy Practices

Please find our Notice of Privacy Practices listed on our website at https://cndlifesciences.com/npp/. By signing this document, I acknowledge that I have received information on CND Life Sciences' Notice of Privacy Practices.

By signing this document, the responsible party also accepts the following,

As record of disclosure:

I. Estimated fees for all services, including unpaid balances, deductibles, co-payments and non-covered services are due at the time of service. Returned check fees up to $25 will be incurred for each returned check. Unpaid balances are subject to collection placement.

II. We have made prior arrangements with some insurance carriers to accept an assignment of benefits. This means we will bill contracted and non-contracted insurance plans and will hold you responsible for the portion the carrier assigns as your responsibility (deductibles, coinsurance, co-pay, non-covered services). We accept outpatient medical plans only.

III. Advance Beneficiary Notice of Non-coverage (ABN), also known as a waiver of liability, is a notice you will receive and sign when you are planning to receive services or treatment that we believe Medicare will not cover. This will serve as a warning that Medicare may not pay for your treatment, but you are agreeing to pay for the services if Medicare rejects the coverage.

IV. Portions collected for laboratory services are estimates only. Once your insurance carrier has addressed the claim(s), you will receive a statement for any remaining balance deemed your responsibility. Payment will be due upon receipt of statement. If your insurance carrier pays you directly for services billed by CND, it is your obligation to promptly forward the payment to us.

V. If arrangements are established between you and our finance department for services rendered, a credit card on file may be used to secure any outstanding balances owed to CND after your insurance plan has paid their portion. This may also be used for deductibles, copayments and any other arrangements established. This process allows CND to resolve open balances in a timely manner.

VI. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co- payments, non-covered charges, etc. We will, however, make certain advanced authorization requests are requested upon advanced notification of intent to test to alleviate as many non-covered fees as possible. Your insurance policy, however, is a contract between you and your carrier. Contact your insurance representative and understand your coverage and benefits prior to undergoing any service/procedure.

cndlifesciences.com | 9165 E Del Camino Dr, Ste 101 Scottsdale, AZ 85258-4381 | Phone: 480.569.2900 | Fax: 480.569.2910 | CLIA# 03D2151444 | CAP# 9235762

STATEMENT OF FINANCIAL RESPONSIBILITY

At CND Life Sciences, Inc., we understand financial problems may affect timely payment. We encourage you to communicate any such problems to our Revenue Cycle Management Department, so that we may assist you in keeping your account in good standing. We may provide you with additional resources such as payment arrangements or SFDS applications. Adjustments will only be made based upon contractual obligations with insurance or with prior written approval. Should you have any questions, please contact our Revenue Cycle Management Department at 480-569-2900, option 1.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

Printed Name of Patient

Date of Birth (Month/Day/Year)

Signature of Guarantor

Date

Printed Name of Authorized Representative

(Complete only if the guarantor is not the patient, the patient is unable to sign, or the patient is a minor.)

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