Please review enrollment information below. Complete form by filling in missing information. Make any corrections by writing changes next to the information provided.

Date:	How much can you afford for this medication ____ ? *You may be responsible for any remaining balance Good Days does not cover.*
SSN:	

PATIENT INFORMATION

Patient's Name:	Birth Date:
Alternate Contact:	Relationship:
Mailing Address:	Home phone:
	Cell Phone:
	Work Phone: Ext:
E-mail Address:	

INCOME INFORMATION

Annual Household Income:	Number of people in household:

PHYSICIAN INFORMATION

Physician Name:	Physician Phone:
Office Address: (*if known*)	Physician NPI:

DIAGNOSIS INFORMATION

Diagnosis:	
Medication:	
Pharmacy:	Pharmacy Address or Phone: (*if known*)

MAJOR MEDICAL INSURANCE INFORMATION

Insurance Name:		
ID#:	Group #:	Phone:

DRUG CARD INFORMATION

Insurance Name:	ID#	
BIN:	PCN:	Phone:

Is this a Medicare, Federal or State funded insurance plan? Yes No *(circle applicable answer)*

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*Metastatic Cancer Diagnoses:

For patients in a metastatic cancer fund: If your physician has prescribed a drug to treat your metastatic cancer that is not on Good Days' formulary, please contact us. We may be able to cover the prescribed drug if we receive additional documentation showing that the drug otherwise meets our criteria. For our metastatic cancer funds, Good Days will cover all drugs approved by the Food and Drug Administration (the "FDA") that treat the type of cancer that is the basis of the disease fund into which you have been accepted. For example, if you have metastatic breast cancer, Good Days will cover all drugs that are approved by the FDA to treat breast cancer, not just those drugs that the FDA has expressly approved for the metastatic stage of breast cancer.

Certification and Acknowledgement:

You agree that all of the information you have provided is truthful and accurate to the best of your knowledge. You understand that you are free at any time to switch providers, practitioners, suppliers, or specialty therapeutics within the Good Days formulary for your diagnosis without affecting your continued eligibility for assistance. Your application for assistance does not guarantee funding will be available. Any financial assistance that you may be eligible for will only be awarded after documentation of your first dispense has been approved by Good Days. You understand that if you are awarded financial assistance that it will be provided on a Calendar Year basis. You must reapply each Calendar Year and the end of the Calendar Year is your notice of cancellation. There is no guarantee that funding will be available in any subsequent year.

Limitation of Liability:

You agree that Good Days, our sponsors, and our donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-pay relief, or other value-added benefits or services provided as a part of this program.

Patient Attestation:

You agree to be fully compliant in taking the drug for which financial assistance is being provided in accordance with your doctor's directions

By signing below you agree that you have read, understand and agree to adhere to the above statements

Signature of Individual or Individual's representative _____ Date _____

Print name of Individual's representative: **(If applicable)** _____ Relationship **(If applicable)** _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ ID: _____

I hereby voluntarily authorize the use and/or disclosure of all or any part of my protected health information ("PHI") as described in this Authorization by Good and its employees, agents, and third parties acting on its behalf for the following purposes:

(1) to enable Good Days to determine whether I am eligible for financial assistance for my medication(s);
(2) to enable Good Days to provide financial assistance to me for my medication(s), if I am eligible for assistance and funding is available; and
(3) to facilitate the audit and/or review of Good Days' operations.

The PHI used and/or disclosed by Good Days may include, but is not limited to, the following: name, address, phone number, email address, date of birth, social security number, insurance status and numbers, amount of financial assistance allocated and dispensed, diagnosis information, and treatment information (e.g., medication, dispense-related information, name of physician and/or pharmacy, etc.).

Good Days may disclose my PHI for the above-stated purposes to its agents, third parties acting on its behalf, or other third parties participating in one of the above-stated activities.

My signature below means that I understand and agree to the following:

- My PHI may be protected by law. My PHI that is disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal and state privacy regulations and laws.
- Good Days will not condition my eligibility for, enrollment with respect to, or payment of financial assistance (and therefore my ability to receive treatment) on whether I sign this Authorization.
- Without my signature below, this Authorization will not be honored.
- I may receive a copy of this form if I ask for it in writing to the following address:

  Good Days HIPAA Security Officer
  6900 Dallas Pkwy, Ste. 200
  Plano, TX 75024
- This authorization will expire six (6) years from the date that I last receive assistance from Good Days, unless I revoke it sooner. If I sign this form, I may revoke this Authorization at any time by notifying Good Days in writing at the above address. Revoking this Authorization will not have any effect on actions that Good Days took in reliance on the Authorization before it received notice of my revocation.
- Good Days may deidentify and reidentify or attempt to reidentify my PHI as necessary for Good Days to provide its services.
- Good Days may electronically disclose my PHI to third parties as permitted or required by law.

_____ _____

Signature of Individual or Representative Date

If this authorization is signed by an individual's representative, the following information must be provided:

_____

Name of personal representative (please print)

_____

Relationship to the individual, including authority for status as representative

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