FIRST STEPS ENROLLMENT FORM

PATIENT INFORMATION:

LAST NAME: _____

FIRST NAME: _____

STREET ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

DOB: _____

FERTILITY CLINIC EMAIL (OPTIONAL) _____

PHARMACY EMAIL (OPTIONAL): _____

PHONE NUMBER: _____

GENDER: ☐ Male ☑ Female

YOUR EMAIL ADDRESS:_____

TREATMENT

Are you currently undergoing treatment with a fertility specialist? ☑ Yes ☐ No

Physician Name: _____

Are you currently undergoing a treatment cycle using donor eggs? ☐ Yes ☑ No *If yes please provide Donor alias name*

Donor Name _____ Donor DOB _____ *(If you don't know your Donor's alias name or DOB please ask your IVF center)*

First Steps provides discounts for the following medications ONLY: Follistim, Ganirelix, Pregnyl

WE WILL NEED YOUR ANNUAL ADJUSTED GROSS INCOME FOR YOUR HOUSEHOLD.

These are the only acceptable documents the First Step Program uses.

- 1040 A
- 1040 EZ
- 1040 MARRIED FILING SEPARATE (Need Both)
- 1040 *** Please submit only the first two pages showing lines 37 & 38 ****

** YOUR SOCIAL SECURITY NUMBER IS NOT NEEDED PLEASE FEEL FREE TO BLOCK THAT OUT ON YOUR 1040**

All Military (active or veteran) Servicemen or women are automatically apprived for a 25% discount when you submit your military information. Military personell can qualify for deeper discounts with the submission of a 1040. If a 1040 is submitted, and the member qualifies for a discount, the greater of the two will be honored.

ACCEPTABLE DOCUMENTS NEEDED FOR THE MILITARY DISCOUNT ARE:

- DD214
- Service Members most recent copy of retirement
- LES (Leave and Earnings Statement)
- CAC or Uniformed Service ID Card

If you have any questions regarding the First Steps Program please feel free to call Helpdesk 855-672-9260 Monday - Friday 8a-8p EST.

PLEASE SUBMIT YOUR ENROLLMENT FORM AND INCOME VERIFICATION TO ONE OF THE FOLLOWING:

MAILING ADDRESS:
2181 E. AURORA RD STE. 201
TWINSBURG, OHIO 44087

EMAIL: firststeps@envisionrx.com
FAX: 855-672-9262

*You will receive an email within 24 hours from the time it is entered into the system. Please check your junk and spam folder for your notification as it tends to filter into there at times. ** Please note that anything submitted on Friday's will not receive a response intil the following business day. The First Steps program is closed weekends and all major holidays.**

Your signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to use and disclose health and other personal information.

PATIENT SIGNATURE_____ DATE _____/_____/_____

General Authorization to Use and Disclose Health and Other Personal Information

I, _____, or my personal representative, hereby authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to DesignRx, LLC and its agents and representatives including any company that helps administer the DesignRx Assist Program (collectively "DesignRx") so that DesignRx may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me about participating in the DesignRx Assist Program;

(2) provide me with materials relating to the DesignRx Assist Program;

(3) verify the accuracy of the information I provide in my application for the DesignRx Assist Program;

(4) provide support services that can assist me with obtaining access to the DesignRx Assist Program products;

(5) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to DesignRx in order to assist DesignRx in accomplishing the purposes described above.

☐ I do not authorize the use or disclosure of any information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by federal and/or state privacy laws. However, I understand that DesignRx will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized personal representative's) separate written consent.

I understand that I am not required to sign this authorization and such refusal will not affect my ability to receive DesignRx Program products, my ability to obtain treatment, or my eligibility for benefits but it will limit my ability to participate in the DesignRx Assist Program.

I understand that this authorization will remain in effect for one year from the date of my signature, unless I revoke it earlier in writing by mailing my revocation to DesignRx, LLC/EnvisionRxOptions, 2181 East Aurora Road, Suite 201, Twinsburg, OH 44087, via facsimile at 855-672-9262, or via email at firststeps@envisionrx.com.

If I revoke this authorization, DesignRx will stop using and disclosing my information once it is received and logged by DesignRx. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation nor will the revocation apply to disclosures made in reliance on this authorization. I understand that revoking my authorization will also limit my ability to participate in the DesignRx Assist Program.

A copy of this authorization is valid as an original. I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____ Date: 06 / 17 / 2015

Signature of patient (or personal representative): _____

Printed Name and Authority/relationship of personal representative (if applicable):

_____