SIGN DATE & RETURN

Direct Compensation Program Prior Authorization Request

(Please sign and return the completed form to receive compensation benefits)

Consumer Information	
Consumer Name	Date of Birth
Street Address	City, State, ZIP
Consumer Phone	Email Address

Please complete this section

□ Yes □ No Would you like to participate in surveys in return for cash card compensation?
□ Yes □ No Would like to know how you can be compensated for referring a friend?
□ Yes □ No Are you interested in receiving information on other health products?
□ Yes □ No Was financial responsibility discussed with you?
□ Yes □ No Do you like the idea of removing added fees from you medical bills?
□ Yes □ No Would you like to learn more on how to remove fees from your medical bills?
□ Yes □ No Would you like to learn more on how to take control of out of pocket cost?
□ Yes □ No Method HCS works with many health care professionals, as well as, national chain vendors (grocery, clothing, health and fitness) who offer discounts for products and services. Would you like notifications with discounts?

Please note any comments that will help Method HCS serve you better:

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HIPAA Consent: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that my health information can and will be used to (1) directly and indirectly conduct, plan or prescribe my treatment, and follow-up among multiple healthcare providers; (2) obtain payment from Medicare, my supplemental insurance, and other third party payers; and (3) conduct normal healthcare operations such as quality assessments and physician certifications. I accept that this information will be used for research, development, and marketing purposes. I agree to receive compensation in form of; cash card rebates, discounts and referral opportunities. I understand that participation to direct compensation programs require product and services payment to Method HCS. I agree to transfer immediately to METHOD HCS any payment made directly to me for product and services by METHOD HCS on an assigned basis. In addition, if payment is made to me, and if I do not transfer payments to Method HCS, I agree to be responsible for the full amount of the charges and all collections and legal remedies including fees. I accept that all required forms must be signed by me before any form of compensation will be given. I accept that Method HCS has the right, at any time, and at their sole discretion, modify, change, and/or discontinue their programs, including the terms and conditions of use, including their privacy policy, with or without notice to the consumer. I attest that the information is accurate and true and that all documentation supporting this information will be stored on a secure HIPAA compliant off-site data storage facility.

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Signature Date