VitalWatch[24] Subscription Rates and Fees Disclosure

Wellness Tier monitoring includes the following services:

- 24-HOUR remote vital sign monitoring via HELO LX+
- 24-HOUR CallBell™ service with RN callback
- Monthly in-home wellness check visit by an RN**
- Frequently scheduled remote health checks with caregiver/MD collaboration
- Monthly health report for clients, caregivers, MD/NPs
- In-home lab specimen collection and delivery
- In-home urine and Coumadin testing

Health Tier monitoring includes ALL Wellness Tier services, plus:

- Bi-weekly in-home RN skilled visits or wellness checks**
- Perform in-home skilled procedures (MD ordered)
- Perform in-home catheter, IV, or feeding tube maintenance and care

Medical Tier monitoring includes ALL Health Tier services, plus:

- Weekly in-home RN skilled visits or wellness checks**

Definition of services:

- **WELLNESS CHECK VISIT** – Any visit performed by an OnCall[24] clinician for in home observation and assessment of current patient health status, review and/or set-up of weekly medications, health history, vital signs, MD collaboration, caregiver collaboration, and any other services or tasks within the scope of practice for a Registered Nurse that are not specifically ordered by a health practitioner. Does not include skilled or ordered tasks, or routine maintenance procedures.

- **SKILLED NURSING VISIT** – Any visit performed by an OnCall[24] clinician for in home performance of any task or procedure which requires a physician, physician assistant, or

nurse practitioner order, and is within the scope of practice for a Registered Nurse. Examples of these types of services include:

- Urinary catheter insertion, removal, or maintenance
- Phlebotomy to obtain blood specimens for purposes of lab testing
- Urine collection via clean catch or one-time catheterization for lab testing
- Gastric or feeding tube nutrition administration or maintenance
- Wound care (no Wound-Vacs. Wound care materials may be supplied on a case by case basis for an additional fee)
- In-home Coumadin and Anticoagulant testing
- Post-surgical and procedure aftercare and monitoring
- Intravenous or central venous access site and line maintenance
- Other ordered skilled services are reviewed on a case by case basis for appropriateness and safety

---

☐ Monthly Service Tier

☐ Wellness Tier	$99.00/month
☐ Health Tier	$169.00/month
☐ Medical Tier	$259.00/month

☐ First Time Admission Fee	$95.00
☐ On-Demand Nurse Visits	$49.00/visit
☐ Supplies and Materials	$_____/month
☐ DISCOUNT $ or %	$_____% /month
Total monthly subscription charge	$_____/month

Initial _____

Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card or withdrawal from your bank account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card or bank statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize Koerner Health Solutions, LLC to charge my
(Cardholder's Name) (Merchant's Name)

Credit Card/Bank Account indicated below for $_____ on the _____ of
(Amount $) (day)
each _____.
(week, month, etc.)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

☐ Credit Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
Account/CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

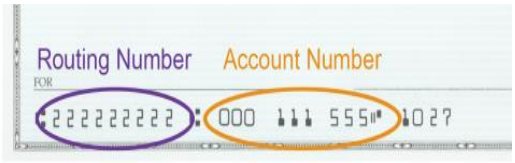
I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify _____ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

I accept the credit card convenience fee of $4 per charge. I understand there is no charge for bank draft transactions.

SIGNATURE _____ DATE _____
(Cardholder's Signature)

☐ ACH/Bank Details

☐ Checking ☐ Savings



Account Name _____
Bank Name _____
Account Number _____
Routing Number _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Koerner Health Solutions, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Koerner Health Solutions, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $_____ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Account Holder's Signature)

SIGNATURE _____ DATE _____
(Admitting Clinician's Signature)