Health First TECHNOLOGIES, INC.

Better Products Better Health…

Welcome to our On-Line Entry Forms System. This **Patient Rental Agreement** is to be **used only when a patient is renting** a NeuroCare™ NC10004PXP unit directly from Health First Technologies. You can print out all of the pages and then complete them off-line, or you can complete them on-line by following the steps shown below. Either the Medical Professional working with the patient or the patient themselves (or both) can complete this paperwork. Regardless of who completes the form, the patient must have a Medical Professional's order recommending home usage by the patient before any rental can take place.

If you are completing this agreement on-line, please complete all the fields on the following pages as follows:

Special note: In the event that **you need assistance in completing any of the information below**, please do not hesitate to contact us at **775-246-1444** and we will be more than happy to assist you. You can also e-mail us at ccc@renua.com with any questions you might have.

1. **Go to Page 2** of this document and **click on the highlighted field** at the top of the page that says **"Patient Name (FIRST, MIDDLE INITIAL, LAST). Then simply enter the patient's full name.**
2. **Click the Tab button** on your computer keyboard to automatically **go to the next field** to complete. From here on out, simply **complete each field** that you are prompted to complete and do **not leave any fields blank**. **Click the Tab button after each field is completed.**
3. When you get to the **credit card fields**, i**f you do not wish to use a credit card for the initial charges,** you can send us **credit card check, cashiers check, or regular check** (which we strongly suggest that you **overnight** to us at **655 Hwy 50 E., Suite 1, Dayton, NV 89403** to avoid potential loss in the mail). When doing so, please make all **checks payable to Health First Technologies, Inc**. **You can also wire funds to us** (when doing so, please **contact us at 775-246-1465** to get those wiring instructions). **But, regardless of which initial payment method you choose,** make sure that you still **complete the credit card fields,** as you **must have a credit card** on file for us to use **to bill you monthly** for your rental costs from that point forward.

   If you wish to finance the initial charges and/or any portion of the monthly rental costs, please contact us at **877-885-1258** to discuss the many options we have available to you.
4. **Once you have completed all the highlighted fields** on every page**,** and are satisfied with what you have entered, **please sign and date every page where applicable (on the UCC-1 form you would sign and date as the Debtor on the lower left side of that page)**.
5. Lastly**, fax all completed pages** to **(775) 546-6156** for review. **Once we receive the paperwork**, we will check it for accuracy and **contact you** to arrange for the **delivery of the equipment** (the only exception being in the event that you choose to **apply to finance the initial payment and/or monthly rental fees**). In this event be sure to contact us at 775-246-1465 before sending in your paperwork.

Sincerely,

HFT/Renua - Client Care Center

Renua Medical (a Health First Technologies Company)
NeuroCare Patient Intake Information

_____ DOB: ___ / ___ / ___ SEX: ____ Male ____ Female
PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

_____ _____
RESPONSIBLE PARTY'S NAME (if different from above) SOCIAL SECURITY#

_____ _____
ADDRESS DRIVER'S LICENSE # STATE PHONE #

_____ _____
CITY STATE ZIP CREDIT CARD # EXP. DATE Security Code

EMPLOYER'S NAME: _____EMPLOYER'S PHONE #:_____

How did the patient hear about NeuroCare? _____

Who first introduced the patient to NeuroCare Therapy? _____

DIAGNOSIS: (ICD-9 CODE) _____

IS THIS CLAIM THE RESULT OF AN ACCIDENT? YES____ NO____

TYPE OF INJURY: ____WORKER'S COMP: ____ AUTO: ____ SPORTS: ____ OTHER: _____

DATE OF INJURY ___ / ___ / ___ CLAIM # _____ CLAIM ADJUSTER: _____

The Patient has been informed that it is their responsibility to obtain coverage for the use of the equipment from their own insurance provider: ___ Y ___ N

(Optional) INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ POLICY # _____ GROUP # _____

POLICY HOLDER'S NAME (if different than patient): _____

REFERRING PHYSICIAN: _____ PHONE #: _____

PRACTITIONER: _____ PHONE #: _____

ORDER FOR EQUIPMENT FROM LICENSED PRACTITIONER ATTACHED? YES___ NO___

Do you have any of the following conditions? If the answer to any of the following questions is yes, your physician will explain treatment precautions and why treatment is indicated. Women who are not sure if they are pregnant must get a pregnancy test.

	YES	NO
An Implanted Pacemaker	___	___
Thrombosis-Phlebitis	___	___
Epilepsy	___	___
Cancerous Lesions	___	___
Varicose Veins	___	___

	YES	NO
Are you pregnant?	___	___
Are you under treatment for any acute problem?	___	___
Are you suffering from any other chronic muscle or nerve Disorder?	___	___

If "YES" please describe below:

_____

Patient agrees to only use the equipment in the manner and for the person for whom the unit is prescribed or ordered.

_____ _____
Patient's SIGNATURE) Print Name DATE

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Renua Medical (a Health First Technologies, Inc. Company)
NeuroCare Patient Rental-Purchase Agreement

_____ DOB: ____ / ____ / ____ SEX: ____ Male ____ Female
PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

_____ _____
RESPONSIBLE PARTY'S NAME (if different from above) SOCIAL SECURITY#

_____ _____
ADDRESS DRIVER'S LICENSE # STATE PHONE #

_____ _____
CITY STATE ZIP CREDIT CARD # EXP. DATE Security Code

WHO INTRODUCED YOU TO HFT: _____ THEIR PHONE#:_____

Patient Personally Responsible for All Payments

While your Medical Provider may provide you with the necessary documentation for YOU to attempt to get your insurance company to reimburse you for all or part of the monthly rental fee for this equipment, the Lessor will NOT bill Medicare, Medicaid, Insurance Companies or HMO's directly for the rental or purchase of this item and obtaining such reimbursement is your sole responsibility as there is no guarantee such insurance coverage for the rental of this equipment is even available. You therefore agree to be solely responsible for making each monthly rental payment.

Deposit Can Be Applied to Final 3 Payments of 36 Month Rental-Purchase Agreement

100% of any payments made (Including the deposit) will apply toward purchase of the $5,000 (+ Tax) NC10004PXP if purchased within 60 days of delivery. Patient understands that the deposit below is used to pay for expenses associated with unit preparation, refurbishment (If necessary), insured shipping and delivery as well as any initial basic telephone training support that may be needed by the Patient, and therefore, the deposit is non-refundable. 100% of the deposit will be applied towards the purchase price of the equipment if the Patient opts to purchase the unit at any time during the rental or extended rental period. The deposit will also be applied to the final 3 monthly payments of a total 36 monthly payments after which the title to the equipment and full ownership rights will be transferred to the Patient with no further payments required. If the equipment is returned and the rental is therefore terminated by the Patient prior to the payment in full of the first 33 monthly rental payments, the deposit will be forfeited and will not be refunded.

The deposit will not be refunded or applied to any payments due if the equipment is returned at any time before the completion of the 36 month Rental-Purchase period by the payment in full of the first 33 monthly rental payments.

Patient's Right to Terminate Rental at Any Time

Patient shall have the right to return the equipment to and terminate the rental at any time during the 36 month rental period, thus terminating the rental and terminating any payment obligations associated with the rental. Such an early termination will forfeit the deposit and no deposit or monthly rental payments that were made will be refunded.

Patient agrees to comply with Lessor's Terms and Conditions of Sale attached to this agreement.

The total purchase price of the NeuroCare NC10004PXP is $5,000 plus tax (If applicable) when purchased in full up front.

UNIT DISPENSED: SERIAL # _____ DATE DISPENSED _____

PRESCRIBED RENTAL PERIOD IN MONTHS _____ MONTHLY RENTAL AMOUNT _____

DEPOSIT ($750 Dep + shppng) _____ Carrying case, power supply, four leads and one pack of electrodes provided with unit: ___Y___Y or N

ELECTRODE PURCHASE: _____ **PKG.** @ ___$10___ /PKG. **=** ___$0.00___ TOTAL START-UP PAYMENT DUE: ___$0.00___
Initial Start-Up Payment due is calculated by adding the $750 deposit to the first monthly payment plus any electrode order amount.

Or make checks payable to: Health First Technologies, Inc., PO Box 20224, Carson City, NV, 89721, 775-246-1444
My signature below is authorization for my credit card to be billed for the Total Start-Up Payment Amount Due shown above and for an automatic charge to be made against my credit card to cover the monthly rental amount prior to each new month.

PLEASE READ THE ADDITIONAL TERMS BELOW TO THIS RENTAL AGREEMENT BEFORE SIGNING.

I HAVE READ, UNDERSTAND AND AGREE TO ALL THE TERMS AND CONDITIONS REGARDING RECEIPT OF THIS EQUIPMENT AS STATED IN THIS AGREEMENT AND IF NECCESSARY I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY MEDICAL PROVIDER TO BE PASSED ON TO THE LESSOR.

_____ _____
(Recipient Patient Renter's SIGNATURE) DATE

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RENUA MEDICAL (A HEALTH FIRST TECHNOLOGIES COMPANY) NEUROCARE™ PATIENT RENTAL-PURCHASE AGREEMENT

The Patient described above agrees to rent a NeuroCare system from the Health First Technologies, Inc. under the following terms and conditions. The equipment to be rented or purchased is provided by Health First Technologies, Inc. doing business at the following address PO Box 20224, Carson City, NV, 89721, telephone number 775-246-1444, hereinafter "Lessor". Ship to Lessor at 655 Hwy 50 East, Ste. 1., Dayton, NV 89403.

RESPONSIBILITY FOR PAYMENT: The Patient (Recipient) agrees to accept full responsibility for payment of all money due to the Lessor for the rental of the NeuroCare equipment delineated above and the purchase of supplies such as electrodes for use with the equipment. All monthly rental payments are due in advance before each rental month and will automatically be charged to the Patient's credit card provided above 3 to 5 days in advance of the next rental month. If the payment is not made, the credit card charge is declined or not cleared in any way; Patient agrees to immediately return the equipment to the Lessor at the Lessor's place of business above delineated. This agreement provides for the protection of the Lessor's property rights to the rented equipment and payment of each monthly rental for the equipment is not contingent upon any possible settlement, judgment or verdict by which recipient Patient may eventually recover damages in any personal injury case. Patient shall be responsible and liable for any and all monthly rental payment charges in their entirety for any monthly period in which the equipment continues to not be return delivered to Lessor's "Ship To" address shown above. Patient will incur another full monthly rental payment charge for each and every month, or any time period of a month in which the equipment is not back in the Lessor's possession. Patient must notify Lessor 10 days in advance of the next rental period of Patient's intent to terminate.

INSURANCE: As a general rule the Lessor will not bill any insurance company for the rental of this item, however, if requested, Lessor may, at its option, invoice the primary insurance carrier for rental of the Equipment by the Patient recipient. The Patient agrees to forward in full to the Lessor any insurance payment made to the recipient for services/products provided by the Lessor for which the Lessor has billed the insurance provider and for which Patient has not already paid Lessor. Payments received by the Lessor from the insurance carrier for amounts previously paid by the Patient will be promptly refunded to the Patient.

RENTAL: The rental period for this equipment is shown on the initial page above to this agreement and is from the delivery date to the Patient's address shown above. Any additional supplies needed by the Patient during the rental of this equipment beyond those provided initially with the equipment will be furnished at an additional charge to the Patient with sales tax if applicable. Patient recipient agrees to pay charges of the rental and continue to pay all charges for continued rental until the date the equipment is returned to the Lessor or Lessor's designated representative.

RENTAL TERM: The term of this Rental Agreement is for the term prescribed by the Licensed Healthcare Practitioner written above on the intake form and shall automatically renew for the same rental term unless either party notifies the other of its intention not to renew. Failure to return said equipment constitutes implicit agreement on the part of Patient recipient that renewal or rental agreement continues in full force and effect.

RETURN OF EQUIPMENT: Recipient Patient agrees to notify Lessor of Patient's intent to return the equipment at least a week before the end of the rental period and to make the necessary arrangements needed to insure that the equipment is delivered back into the control and possession of the Lessor at the Lessor's address, or if approved in writing by Lessor, into the hands of Lessor's designated representative, before the end of the rental period, or another monthly rental payment charge will be incurred by the Patient. Patient agrees to return the equipment to Lessor within 24 hours upon the demand of Lessor in the manner instructed by Lessor. Failure to return the equipment upon demand obligates the Patient to pay Lessor $5,000.

PROPERTY RIGHTS TO THE RENTED EQUIPMENT: Rented items remain the property of the Lessor and the Patient recipient agrees that all items are received in good condition. If asked, Patient agrees to sign a UCC-1 Lien form which the Lessor may or may not file with the State to further protect the Lessor's rights to the equipment. Lessor's ownership rights in the rented equipment will not be compromised by Lessor's failure to file a UCC-1.

CARE AND PROTECTION OF THE EQUIPMENT: Patient agrees to be responsible for the care and protection of the equipment rented herein and Patient agrees to pay in full for any loss or damage to the equipment from fire, theft, carelessness, or other causes, at the value of the equipment stated herein which **value is $5,000** plus any applicable taxes per unit. The same payment obligation applies to non-returned units.

CONDITION OF RETURNED RENTED EQUIPMENT: Patient agrees to return the equipment rented in the same condition as it was in when it was initially delivered to the Patient minus ordinary wear and tear. In the event of loss or irreparable damage to the equipment, recipient accepts full responsibility for paying the Lessor the purchase price as stated above.

USE OF EQUIPMENT: Patient agrees that the medical equipment rented herein will be used solely by the Patient for the Patient's own needs as prescribed by the Patients Healthcare Practitioner.

INDEMINIFICATION: The Patient agrees to save, hold harmless and indemnify the Lessor against any and all liability or loss whatsoever resulting from the Patient's use of rented equipment.

DAMAGED OR MALFUNCTIONING EQUIPMENT: The Patient agrees to immediately cease using any item via this agreement if it becomes unsafe or in disrepair. Recipient will immediately notify the Lessor or its designated representative of any such damage to the equipment and the Lessor agrees to replace the damaged rented item with reasonable dispatch upon Lessor's receipt of the malfunctioning unit.

WARRANTY OF USE: Beyond a general explanation of the claims pertaining to the use of the equipment authorized by the FDA, neither the Lessor nor the Lessor's designated representative make any claims, warranties or representations regarding the suitability of the treatment provided by the equipment rented herein, as such claims are the province of the prescribing Practitioner. The Lessor makes no guarantees and assumes no responsibility for the success or failure of any treatment administered using the equipment rented via this Agreement.

TITLE TO THE EQUIPMENT: Nothing in this Agreement shall be construed to transfer any equipment title or ownership to the Patient unless and until it is purchased by Patient and paid in full at the price shown above. With the Patient's continued timely payment of each monthly rental payment for 33 months, the deposit shall be applied to the final three monthly payments of the 36 month Rental-Purchase Agreement at which time the full Title and ownership of the equipment will be transferred to the Patient. The Patient can also opt to purchase the equipment at any time for the full purchase price shown above with 100% of the deposit applying toward the purchase price. Any rental payments made via this agreement will only apply toward the purchase if the purchase is made within the first 60 days after delivery. All payments are non-refundable under this agreement.

DEFAULT: The recipient agrees to make all payments and/or accept all credit card charges herein required in the time and manner prescribed. In the event that recipient does not perform any or all of the terms and conditions of this agreement, Recipient agrees that the Lessor may, at its option, take any or all necessary actions including the following: a. Patient shall accrue late charge penalties at the rate of 1.5% per month on all past due balances; b. Lessor may demand the immediate return of the equipment; c. Exercise any right or remedy granted the Lessor under or pursuant to any laws of the state within which the Lessor does business.

RELEASE INFORMATION: The Patient hereby authorizes the Lessor to obtain all information that the Lessor may require from Patient's past healthcare providers or the prescribing provider and from other sources if such information is needed to facilitate this rental.

ASSIGNMENT: The Patient does hereby request that any payments made under the Patient's medical insurance program be made directly to the Lessor for items rented herein. Any Payments received by Lessor from such sources for services Patient has already paid for will be promptly refunded to Patient by Lessor. MEDICARE REGULATIONS CONCERNING THIS ASSIGNMENT AGREEMENT APPLY.

CHANGES TO AGREEMENT: This agreement sets forth the entire understanding between Recipient Patient and the Lessor. No provision shall be changed except by amendment in writing, signed by all parties concerned.

I HAVE READ, UNDERSTAND AND AGREE TO ALL THE TERMS AND CONDITIONS REGARDING RECEIPT OF THIS EQUIPMENT AS STATED IN THIS AGREEMENT AND IF NECCESSARY I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE LESSOR.

_____

(PATIENT'S SIGNATURE) DATE

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UCC-1 FINANCING STATEMENT

(Non Real Estate Related Collateral Only)

1. Debtor's Legal Name and Mailing Address:

2. Secured Party's Legal Name and Mailing Address:
Health First Technologies, Inc.
PO Box 20224
Carson City, NV 89721
Tel: 877-885-1258
Fax: 775-546-6156
Email: ccc@renua.com

3. Assignee's Legal Name and Mailing Address:

4. This financing statement covers the following types or items of property (referred to herein as the "Collateral"):

All right, title and interest of Debtor, whether now owned or hereafter acquired, in and to the collateral described on Exhibit "A" attached hereto, together with all additions, accessions, replacements, and substitutions thereto and therefore, and proceeds and products thereof. The collateral is located at the mailing address of Debtor set forth above..

THIS IS A TRUE FILING EVIDENCING AN AGREEMENT BETWEEN SECURED PARTY AS LESSOR AND DEBTOR AS LESSER. NO SECURITY INTEREST IS BEING EVIDENCED HEREBY AND NO TRANSFER TAX IS DUE.

Proceeds and products of Collateral are also covered.

5. Maturity Date (if more than 5 years and not more than 20 years): _____

6. Number of additional sheets presented: 1

7. The Collateral secures total principal indebtedness of ____$ 4,995 per unit delivered or a total value of _____. _____ State recording tax has been paid on $_____ of that indebtedness:

[ ] with the recording of deed of trust in Book _____, Page _____ in the Register's Office of _____ County, _____ State.

[ ] with the recording of a financing statement no. _____ in the Office of _____.

[ ] pursuant to the attached Sworn Statement.

Evidence of payment is attached. Tax on $_____ of the principal indebtedness is being paid with this filing.

THE MAXIMUM PRINCIPAL INDEBTEDNESS FOR _____ STATE RECORDING TAX PURPOSES IS $_____.

8. If the Secured Party is signing this statement instead of the debtor, it is because:

[ ] The Collateral covered by this financing statement is already subject to a security interest in another jurisdiction where it was or will be brought into _____ State or when the debtor's location has been or is being changed to _____ State.

[ ] The Collateral represents proceeds of Collateral in which the Secured Party had a perfected security interest. The original Collateral was _____.

[ ] The filing on the Collateral has lapsed.

[ ] The Collateral was acquired after a change of the Debtor's name, identity or corporate structure.

9. DEBTOR AND EQUIPMENT LOCATION:

By:_____

Title:

10. SECURED PARTY:
Health First Technologies, Inc.
PO Box 20224
Carson City, NV 89721
Tel: 877-885-1258
Fax: 775-546-6156
Email: ccc@renua.com

By:_____

Title:

11. ASSIGNEE:

By:_____

Title:

This financing statement is being filed with the Office of the Secretary of State in which the equipment is placed.

© 2010 Health First Technologies, Inc. All Rights Reserved Lessee Initials_____