GAME READY®

Patient Sale Agreement

NEED ASSISTANCE? Troubleshooting or Service: 1.888.426.3732 **Billing or Payment:** 1.800.859.8206

PAYMENT TYPE: ☐ Private Insurance ☐ Cash Purchase/Self Pay* ☐ Workers' Compensation ☐ TriCARE Active Duty Military ☐ No Fault Auto
*Insurance carriers require a HICFAA 1500 form for all claims submissions. Without this, your insurance carrier will likely reject self-submissions. If you plan to submit to insurance for reimbursement please do not choose "Self Pay". CoolSystems®, Inc. will be unable to provide a claim form after the fact.

CUSTOMER INFORMATION: (hereinafter "Patient")

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____ Cell: (_____) _____ - _____

E-Mail Address: _____

Are you interested in getting email updates from time to time? ☐ Yes ☐ No

Date of Birth: _____ - _____ - _____ *(for Patient identification purposes only)*

Social Security Number: _____ - _____ - _____

SHIP TO ADDRESS:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____

Delivery Comments: _____

GAME READY REPRESENTATIVE/AGENT INFORMATION:

Representative: _____

Contact Phone: (_____) _____ - _____ Ext. _____

EQUIPMENT ACCESSORIES

☐ Game Ready Control Unit ☐ Carry Bag ☐ Battery Pack

Wraps: ☐ Ankle ☐ Articulated Knee ☐ Back ☐ Elbow ☐ Flexed Elbow ☐ Half-Leg Boot ☐ Hand ☐ Hand/Wrist ☐ Hip/Groin
☐ Knee ☐ Shoulder **Traumatic Amputee Wraps**: ☐ Above-Knee ☐ Below-Knee ☐ Utility

Side: ☐ Right ☐ Left **Size:** ☐ Medium ☐ Large ☐ XL **Other**: _____

PAYMENT METHOD: Drivers License # _____ State: _____ Authorization Code: _____ Authorization Date: ____ / ____ / ____

Check #: _____ Amount Paid: $_____ EFT Routing # _____ Bank Account # _____ Bank Name: _____

We will charge your credit card for the Deposit and any/all future unpaid balance(s) due. **Charges on your bank/credit card statement will appear as CoolSystems, Inc.**

Type of Card: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover Number: _____ CVV: _____ Expiration Date: ____ / ____ /____

Name on Card: _____ Signature: _____ Date: ____ / ____ / ____

TERMS AND CONDITIONS: The Patient hereby certifies that the information given to CoolSystems, Inc. in applying for equipment/accessory purchase is true and correct, and authorizes CoolSystems or its designee to bill any third party payors and request that payment of authorized benefits be made to CoolSystems or its designee on the Patient's behalf. Patient authorizes CoolSystems to file an appeal as required due to their health insurance plan's initial or subsequent claims denial and/or benefit determination. Patient fully understands that, in the event that his/her insurance plan does not pay CoolSystems in full, s/he will be financially responsible for all unpaid balances, including applicable sales tax, co-payments and deductibles, less any deposit paid, and will pay such amounts within thirty (30) days of notice from CoolSystems. If litigation is instituted to collect any unpaid balance, Patient agrees to pay all costs of collection, including reasonable attorney's fees, incurred by CoolSystems.

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION: You hereby authorize CoolSystems, Inc. and/or any related parties associated with this transaction to release to third party payers, insurance companies, health insurance insurers, or medical necessity/ utilization review organizations, any information needed to determine payment of authorized benefits until all outstanding charges for you associated with CoolSystems equipment/accessories have been paid. You further agree that CoolSystems, its employees, agents, representatives, Business Associates, and accrediting and governmental agencies may access, request, and receive from healthcare providers involved in your care, and use or disclose your medical information for the purposes of providing CoolSystems equipment/accessories, obtaining/substantiating payment for equipment/accessories, and administering related business operations, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended.

PATIENT ACKNOWLEDGEMENT: This agreement consists of all of the terms and conditions on this page and the reverse side whether written or printed. I certify that I have read the terms and conditions of this agreement and agree to be bound by such provisions. I accept full responsibility for all services rendered, including being informed of my rights, responsibilities, and complaint procedure.

PATIENT SIGNATURE, PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE: (use if Patient has a legal guardian or is under the age of 18.)

Patient Signature: _____ Date: _____

Authorized Personal Representative Name (print): _____

Authorized Personal Representative Signature: _____ Date: _____

ORGANIZATION REPRESENTATIVE SIGNATURE (FOR PROFESSIONAL SPORTS TEAMS, COLLEGES, OR UNIVERSITIES ONLY)

If litigation is instituted to collect any unpaid balance, the organization agrees to pay all costs of collection including reasonable attorney's fees incurred by CoolSystems.

☐ **Professional Sports Team, College or University**: I understand that CoolSystems has agreed to bill the patient's insurance carrier as a courtesy to the patient and our organization. Unpaid claims within 120 days of submission to the primary carrier will immediately become the responsibility of my organization. CoolSystems shall not be required to appeal negative coverage decisions on behalf of the patient and/or the organization. I understand and agree that in the event that the patient's insurance carrier does not pay CoolSystems in full the retail rate of the system and supplies provided, including applicable taxes and freight charges, that the organization will be fully responsible for 100% of all unpaid balances and will pay such amounts within thirty (30) days of notice from CoolSystems. I acknowledge that any contractual discounts or allowances taken on behalf of a third party administrator, bill-review organization, or managed care organization (MCO) shall not apply to this transaction and that the original billed amount is the full balance and shall be due and payable; less any monies paid by the patient's primary and/or secondary insurance. I further acknowledge that I am duly authorized to enter into this financial agreement on behalf of my organization.

Name of Team or School: _____ Date: _____

Representative Signature: _____ Date: _____

CoolSystems, Inc. Representative Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

CoolSystems is committed to protecting your privacy and has developed policies and procedures to ensure that the information you provide to us is collected and maintained in a confidential manner. This Notice of Privacy Practices describes how we collect, use and disclose the information you provide to us and your rights with respect to that information. Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How We Use or Disclose Your Health Information:

For Health Care Operations: Your health information may be disclosed to employees or business associates of the company when needed to provide you with products and/or services, to secure payment for products and/or services provided, and as needed to operate our business. Employees and business associates of the company will only be provided with the minimum necessary information needed to complete their duties. **For Treatment:** Your health information may be disclosed to other healthcare professionals for the purpose of providing you with quality healthcare. **For Payment:** Your health information may be disclosed to your insurance provider for the purpose of the company receiving payment for providing you with needed healthcare products and services. **For Reminders:** Your health information may be used or disclosed to contact you to remind you of the need to re-order regular and routine supplies that you currently receive from the company, or to notify you of other health services that may be of interest to you. **As Required by Law**: We may use or disclose your health information when required to do so by federal, state or local law. **To Persons Involved With Your Care:** Your health information may be disclosed to a person involved in your care or who helps pay for your care, such as a family member, provided you agree to this disclosure or we give you an opportunity to object to the disclosure. If you unavailable or unable to object, we will use our best judgment to decide whether this disclosure is in your best interests. **To Avoid a Serious Threat to Health or Safety:** Your health information may be disclosed when necessary to avoid a serious threat to your health and safety or the health and safety of the public or another person. **Public Health Activities:** Your health information may be released to a public health organization or federal organization in the event of the need to report a communicable disease or to report a defective device. **For Health Oversight Activities:** Your health information may be disclosed to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations. **Judicial or Administrative Proceedings:** Your health information may be disclosed in response to a court or administrative order if you are involved in a lawsuit. We may also disclose your confidential health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice) or to obtain an order protecting the information requested. **Specialized Government Functions:** Your health information may be disclosed for specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others. **Law Enforcement Purposes:** Your health information may be disclosed to law enforcement officials for purposes such as providing limited information to locate a missing person or report a crime **For Reporting Victims of Abuse:** Your health information may be disclosed to government authorities that are authorized by law to receive information about victims of abuse, crime, or domestic violence, including a social service or protective service agency. **Worker's Compensation:** Your health information may be disclosed for workers compensation, as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness. **Business Associates:** Your health information may be disclosed to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of February 17, 2010, our business associates also will be directly subject to federal privacy laws. **Data Breach Notification:** Your contact information may be used to provide notices of unauthorized acquisition, access, or disclosure of your health information as required by law. **Personal Representatives:** Your health information may be disclosed to you or a person who is legally authorized to act for you such as a parent, legal guardian, administrator or executor of your estate, or individual authorized under applicable law. **Your health information <u>may not</u> be disclosed for any other purpose than that which is described in this notice** without requesting a specific written authorization from you to disclose information for a specific purpose. If you give us authorization to disclose your confidential health information, you may revoke (cancel) your authorization in writing at any time, except if we have already acted based on your authorization. To revoke an authorization, send a written notice to Reimbursement Manager, 1800 Sutter St., Ste. 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206.

<u>YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION IN OUR RECORDS</u>

You have the right to restrict uses or disclosures of your information for treatment, payment or health care operations. You also have the right to restrict disclosures to family members or someone who is involved in your health care or payment for your health care. Please note that we are not required to agree to your request. If we agree, we will comply with your request except in certain emergency situations or as required by law. **You have the right to request that we not send health information to health plans in certain circumstances** if the health information concerns a health care item or service for which you have paid us out of pocket in full. **You have the right to receive confidential communications about your health status and the products and services provided to you in an alternative manner or location** (e.g., requesting information be sent to a post office box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept requests to receive confidential communications, modify or cancel a previous confidential communication and the request must be made in writing. You can mail your request to the address listed below. **You have the right to review and obtain a copy of health information that may be used to make decisions about you such as medical records.** You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. You can mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information, in which case, you may request that the denial be reviewed. We may charge a reasonable fee for any copies. **You have the right to request that we amend health information that we maintain about you if it is incorrect or incomplete**. Your request must be in writing and provide the reasons for the requested amendment. If we deny your request, you may have a statement of your disagreement added to your health information. You can mail your request to the address listed below. **You have the right to receive an accounting of certain disclosures of your health information.** This is a list of the disclosures made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting. **You have the right to receive a copy of this Privacy Notice upon request.** This copy can be in the form of an electronic transmission or on paper. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

<u>CHANGES TO THIS NOTICE OF PRIVACY PRACTICES</u>

The Company will abide by the terms of this notice. The Company reserves the right to make changes to this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and any information we receive in the future. Patients will receive a mailed copy of any material changes to this notice within 60 days of making the changes.

<u>SUBMITTING A WRITTEN REQUEST</u>

Mail to us your written requests for: (i) confidential communications or to modify or cancel a prior confidential communication request; (ii) copies of your records, or (iii) for amendments to your record, at the following address: Game Ready, Attn: Reimbursement Manager, 1800 Sutter St., Ste. 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206.

<u>FOR MORE INFORMATION OR TO REPORT A COMPLAINT</u>

If you have questions about this notice or want to exercise any of your rights please contact: Game Ready, Attn: Reimbursement Manager, 1800 Sutter St., Ste. 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206. You may file a complaint with the Company if you believe your privacy rights have been violated and there will be no retaliation. To file your complaint, please mail it directly to the Company at the following address: Game Ready, Attn: Privacy Officer, 1800 Sutter St., Ste. 500, Concord, CA 94520. All complaints will be investigated. If you have questions or concerns that CoolSystems could not resolve, you may also call the Community Health Accreditation Program (CHAP) at 1.800.656.9656. **Attention Florida Residents (only):** To report a complaint regarding the services you receive, please call the Florida Agency for Healthcare Administration (AHCA) toll-free at 1.888.419.3456. To report abuse, neglect, or exploitation of a disabled adult or an elderly person, please call the Florida Abuse Hotline toll-free at 1.800.962.2873. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

CLIENT/PATIENT BILL OF RIGHTS

As a client/patient, you have the right to:

1. Access to homecare equipment and services regardless of your race, creed, religion, sex, or source of payment.
2. Request and receive an itemized, detailed explanation of your bill for equipment and services.
3. Be allowed reasonable participation in decisions regarding your homecare services.
4. Be communicated with in a way that you can reasonably understand.
5. Refuse treatment (as permitted by law). If you refuse treatment, you have the right to be informed of the medical consequences.
6. Choose your provider of homecare services and/or receive our assistance in finding and transferring your homecare services to another provider.
7. Receive homecare services in a timely manner, appropriate for your needs, and have competent and qualified people carry out such services.
8. Be treated with respect and consideration, to be assured of confidentiality in your treatment, and records of your treatment.