INTEGRATED SURGICAL SOLUTIONS

BENEFIT ASSIGNMENT, AUTHORIZATION & CONSENT

SURGICAL PROCEDURE AND MEDICAL DEVICES

IPG has partnered with your health insurance plan, facility and doctor to provide implantable device(s), biologics or other covered tools and supplies that may be needed in your upcoming procedure. If any of these items are used in your surgery, you will receive a bill directly from IPG for the parts used in your procedure. **This is separate from any bills you may receive from your doctor or facility.** *To access all of your Health Insurance Portability and Accountability Act (HIPAA) rights and IPG's notification of privacy practices, visit http://www.ipgpatient.com/hipaa/*

RELEASE OF INFORMATION FOR PAYMENT PURPOSES

For IPG to bill for and receive reimbursement from your health insurance plan(s) for these devices, IPG will need specific Personal Health Information (PHI) including, but not limited to: name, address, date of birth, phone number(s), insurance plan information and pertinent medical information. Your health insurance plan is permitted by federal laws to release this information for payment purposes. You can revoke this authorization at any time according to your patient rights below.

PATIENT CONSENT & RIGHTS

By signing this form, I understand that:

- HIPAA permits healthcare providers and health insurance plans to use and disclose personal health information (PHI) for payment purposes without my authorization.
- Because IPG is seeking a written authorization, I may refuse to sign this Authorization. If I refuse, IPG may not be able to verify my benefit coverage, review my clinical information, obtain medical records, conduct precertification and/or predetermination on my behalf, assist and/or conduct appeals and provide patient service support or provide medical device services.
- My health care provider and health insurance plan(s) will not condition or refuse my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits based upon my agreement to sign this authorization.
- At any time, I may revoke this Authorization in writing by mailing to: IPG Attn. Patient Services, 11605 Haynes Bridge Rd., Suite 200, Alpharetta, GA 30009 or faxing to 866-753-0194 a signed letter of revocation to IPG Attn: Patient Services.
- Revoking this Authorization will prohibit disclosures of information that identifies me after the date my letter of revocation is received and processed by IPG and my health insurance plan(s), but will not affect IPG's ability to use and disclose the information IPG received prior to the receipt of the revocation.
- IPG's notification of HIPAA Privacy Policy provides information about how IPG may use or disclose PHI.
- IPG reserves the right to change the privacy policy as allowed by law.
- I am entitled to a copy of this Authorization.

CONSENT TO RELEASE INFORMATION & BENEFIT ASSIGNMENT

By signing this form, I hereby:

- Verify and confirm that I am legally authorized to consent to treatment and I am financially responsible for the patient/beneficiary deductible and/or co-insurance, as applicable. I authorize my health insurance plan(s) to assign payment directly to IPG for any charges billed by IPG and covered by my insurance plan(s).
- Authorize my doctor(s), and their staff, representatives, affiliates or agents, to release to IPG my contact information, health insurance information and personal medical information or records pertaining to my procedure for the sole purpose of helping to resolve claims and health benefit coverage issues.
- Verify and confirm that if I do not sign this form or revoke it, and IPG cannot complete the claims process with my health insurance plan(s) for lack of necessary information, I may be held responsible for the allowed charges that are unpaid by my insurance plan(s).

☐ IPG may leave voicemails on the contact numbers on file regarding my surgery, insurance claims, bills or statements and collection efforts.

☐ IPG may speak with the following person on my behalf:

NAME _____ RELATIONSHIP TO PATIENT _____ DATE OF BIRTH (FOR VERIFICATION PURPOSES) _____

NAME OF PATIENT (PRINT) _____ PATIENT DATE OF BIRTH _____ PATIENT SIGNATURE _____ DATE _____

IF APPLICABLE, LEGAL REPRESENTATIVES SIGN BELOW:

I verify and confirm that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship documents, etc.) that I am legally authorized to act on the patient's behalf with respect to this form.

NAME OF LEGAL REPRESENTATIVE (PRINT) _____ SIGNATURE OF LEGAL REPRESENTATIVE _____ DATE _____

NAME OF WITNESS _____ SIGNATURE OF WITNESS _____