GAME READY

1.888.426.3732

Patient Rental/Sale Agreement and Order

www.gameready.com CA

CUSTOMER INFORMATION:

Name: ______________________

Address: ______________________

City: ______________ State: ________ Zip: ____________

Telephone: (____) ______ - ________ Cell: (____) ______ - ________

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

Delivery Comments: ______________________

GAME READY REPRESENTATIVE/AGENT INFORMATION:

Representative: ______________________

Contact Phone: (______) _______ - _________ Ext. ___________

Start Date: _____ / _____ / _____ Number of Days: ___________

Stop Date: _____ / _____ / _____ Number of Days: ___________

NEED ASSISTANCE?

- *Equipment Pick-up? - contact your Game Ready Representative listed above*
- ***Troubleshooting or Service?*** *- ask for Customer Service at 1.888.426.37*
- ***Billing or Payment?*** *- ask for Medical Billing at 1.866.500.0587*

NEW CUSTOMER – INITIAL EQUIPMENT SET-UP CHECKLIST

- ☐ Physician's Prescription for Use Reviewed with Patient
- ☐ *Control Unit User's Manual* & *Quick Start Guide* Reviewed with Patient
- ☐ Basic Safety Precautions & Contraindications Reviewed with Patient
- ☐ HIPAA Privacy Policy & Patient Bill of Rights Reviewed with Patient
- ☐ Instructions Provided on How to Contact Game Ready
- ☐ Patient Demonstrated Appropriate Use of Product

EQUIPMENT AND ACCESSORIES **Game Ready Unit Serial Number:** ______________

☐ Knee ☐ Articulated Knee ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Ankle ☐ Hip ☐ Back / ☐ Right ☐ Left / ☐ Medium ☐ Large ☐ X-Large

TERMS & CONDITIONS: I acknowledge that I have inspected and been instructed in the product features and proper use and care of the equipment and/or accessories list above, and have received them in good condition and accepted them as is. I assume full responsibility for said equipment/accessories and agree to protect same from all loss a damage. I understand that I am liable for any damage to any of said equipment that occurs or is caused during the period of this rental/sale agreement, and if rental I a responsible for returning the equipment/accessories to the CoolSystems representative by notifying the representative upon the stop date, or if no longer used by the patient, or t patient's physician discontinues the prescription for this equipment. I understand that the minimum rental period is 7 days, and future rental periods are billed in 7 day increments.

INSURANCE BILLING & ASSIGNMENT OF BENEFITS: I certify that the information given to CoolSystems in applying for equipment/accessory rental is true a correct, and I authorize 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 r behalf. I authorize CoolSystems to file an appeal as required due to my carrier's initial or subsequent claims denial and/or benefit determination. I understand that I will be billed f the rental equipment while it is in my possession. I understand that billing will be stopped on the earlier of the end of my prescribed use, the pick-up date listed on this agreeme or the day CoolSystems receives a call requesting pick-up of the equipment/accessories; subject to the 7 day rental period described above. I fully understand that, in the event th my insurance carrier does not pay CoolSystems in full, I will be financially responsible for all unpaid balances, including co-payments and deductibles, and will pay such amour within thirty (30) days of notice from CoolSystems. If litigation is instituted to collect any unpaid balance, I agree to pay all costs of collection, including reasonable attorney's fee incurred by CoolSystems. I acknowledge that I have read, understand, and agree to these terms and conditions as stated. I authorize filing a lien against any and all third pa liability action relating to the need for treatment, including workers' compensation cases. **For questions regarding your financial responsibility, contact our Medical Billing Departme at 1.866.500.0587.**

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION: I hereby authorize CoolSystems, Inc. and/or any holder of medical information about me to relea to third party payors, insurance companies, health insurance insurers, or medical necessity/utilization review organizations, any information needed to determine payment authorized benefits until all benefits associated with CoolSystems equipment/accessories have been paid. I further agree that CoolSystems, its employees, agents, representative Business Associates, and accrediting and governmental agencies may access, request, and receive from healthcare providers involved in my care, and use or disclose my medi information for the purposes of providing CoolSystems equipment/accessories, obtaining/substantiating payment for equipment/accessories, and administering its own busine operations, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (*see reverse side for Privacy Policy*).

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 t 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 complai procedure. I have been instructed on the safe and proper use of the equipment and/or accessories and/or supplies provided and agree to notify CoolSystems immediately wh medical necessity for the product has ended. I have received a copy (*see reverse side*) of the Patient Bill of Rights, the HIPAA Privacy Rights, and the appropriate safety and usa guides as applicable.

I acknowledge that I have read, understood, received a copy, and agreed to the terms and conditions stated above and on the reverse side, and I have received a complete copy this agreement.

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

Signature ______________________ Date: ____________

Authorized Personal Representative Name (print) ______________________

Authorized Personal Representative Signature: ______________________ Date: ____________

Instructions Completed By: ______________________ Date: ____________
Game Ready Representative

PAYMENT METHOD: In the event that your insurance carrier does not pay CoolSystems™ in full, you understand that you are responsible for all unpaid balances and will pay such amounts within thirty (30) days of notice from CoolSystems™. For your convenience, we will charge your credit card for any unpaid balance due.

Type of Card: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover Number: ______________ Expiration Date: ___ / ___ / ___

Name on Card: ______________ Signature: ______________ Date: ___ / ___ / ___

White Copy – CoolSystems, Inc. Yellow Copy – Patient

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