BENEFIT ASSIGNMENT, AUTHORIZATION & CONSENT

SURGICAL PROCEDURE AND MEDICAL DEVICES

As part of your surgery, your physician may use a medical device service to supply the implant device(s), biologics, and/or supplies used in your upcoming procedure. Implantable Provider Group (IPG) will handle the billing and reimbursement from your insurance company(s) for the medical device service. **You will be billed separately by IPG for your deductible and/or co-insurance and may be responsible for paying the balance based on your benefits at the time of your procedure.**

TO ACCESS ALL OF YOUR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS AND IPG'S NOTIFICATION OF PRIVACY PRACTICES, VISIT HTTP://WWW.IPG.COM/HIPAA/

RELEASE OF INFORMATION FOR PAYMENT PURPOSES

For IPG to process the medical device service request and to obtain reimbursement, IPG will need specific Personal Health Information (PHI) including, but not limited to: name, address, date of birth, phone number(s), insurance information and pertinent medical information to process the claim with your insurance plan(s). Your healthcare provider 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 insurance plans to use and disclose personal health information (PHI) for payment purposes without my authorization.
- I also understand that 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 insurance 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 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 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 insurance plan(s) to assign payment directly to IPG for any charges billed by IPG and covered by my insurance plan(s).

By signing this form, I am also authorizing my physician, their staff, representatives, affiliates or agents, to release to IPG my contact information, 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. I further understand that if I do not sign this form or revoke it, and IPG cannot complete the claims process with my insurance plan(s) for lack of necessary information (including but not limited to medical records), I may be held responsible for the allowed charges that are unpaid by my insurance plan(s).

NAME OF PATIENT (PRINT) | SIGNATURE OF PATIENT | DATE

IF APPLICABLE, LEGAL REPRESENTATIVES SIGN BELOW:

I represent 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 authorization form.

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

NAME OF WITNESS | SIGNATURE OF WITNESS