# NEW PATIENT INFORMATION

*This Section is for Office Use:* Date: _____ Patient #: _____

## PATIENT INFORMATION

| Patient's First Name | M.I. | Last Name | Date of Birth | Social Security |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip Code | Gender |
|---|---|---|---|---|
| | | | | ☐ M ☐ F |

| Phone 1 | Phone 2 | Email | Marital Status |
|---|---|---|---|
| | | | ☐ S ☐ M ☐ D |

## EMERGENCY/GUARDIAN CONTACT INFORMATION

| **Contact 1** First Name | M.I. | Last Name | Relationship to Patient |
|---|---|---|---|
| | | | ☐Self ☐Spouse ☐Parent ☐Guardian |

| Phone | Email |
|---|---|
| | |

| **Contact 2** First Name | M.I. | Last Name | Relationship to Patient |
|---|---|---|---|
| | | | ☐Self ☐Spouse ☐Parent ☐Guardian |

| Phone | Email |
|---|---|
| | |

## PRIMARY INSURANCE INFORMATION *(required)*

| Name of Insurance Company | | | Insurance Phone |
|---|---|---|---|
| | | | |

| Member ID # | Group # | Plan # |
|---|---|---|
| | | |

| Insured's Name *(if not the patient)* | Insured's Date of Birth | Insured's Social Security | Relationship to Patient |
|---|---|---|---|
| | | | ☐Self ☐Spouse ☐Parent ☐Guardian |

| Adjuster's Name | Phone | Email | Fax |
|---|---|---|---|
| | | | |

| Nurse/Case Manager's Name | Phone | Email | Fax |
|---|---|---|---|
| | | | |

## SECONDARY INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

| Name of Insurance Company | | | Insurance Phone |
|---|---|---|---|
| | | | |

| Member ID # | Group # | Plan # |
|---|---|---|
| | | |

| Insured's Name *(if not the patient)* | Insured's Date of Birth | Insured's Social Security | Relationship to Patient |
|---|---|---|---|
| | | | ☐Self ☐Spouse ☐Parent ☐Guardian |

| Adjuster's Name | Phone | Email | Fax |
|---|---|---|---|
| | | | |

| Nurse/Case Manager's Name | Phone | Email | Fax |
|---|---|---|---|
| | | | |

continued on next page

# NEW PATIENT INFORMATION

*This Section is for Office Use:* Date: _____ Patient #: _____

## OTHER INSURANCE INFORMATION *(complete this section if you have additional insurance coverage)*

| | | | |
|---|---|---|---|
| Name of Insurance Company | | | Insurance Phone |
| Member ID # | Group # | | Plan # |
| Insured's Name *(if not the patient)* | Insured's Date of Birth | Insured's Social Security | Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian |
| Adjuster's Name | Phone | Email | Fax |
| Nurse/Case Manager's Name | Phone | Email | Fax |

## IF NOT INSURED

| | |
|---|---|
| Self Pay: ☐ Credit Card ☐ Payment Plan ☐ Check | Other: |

## HEALTH CARE PROVIDERS

List all heath care providers including physicians, specialists, clinicians, physical and occupational therapists, prosthetists and othotists so we may contact them to obtain patient's medical background/history and any other information that will help us process your claim.

| | | |
|---|---|---|
| **Name 1** | Specialty | Clinic |
| Address | Phone | Fax |
| **Name 2** | Specialty | Clinic |
| Address | Phone | Fax |
| **Name 3** | Specialty | Clinic |
| Address | Phone | Fax |
| **Name 4** | Specialty | Clinic |
| Address | Phone | Fax |
| **Name 5** | Specialty | Clinic |
| Address | Phone | Fax |
| **Name 6** | Specialty | Clinic |
| Address | Phone | Fax |

continued on next page

# NEW PATIENT INFORMATION

*This Section is for Office Use:* Date: _____ Patient #: _____

## INJURY ILLNESS INFORMATION

Type of Illness/Injury

- ☐ Chronic Pain
- ☐ Spinal Cord Injury
- ☐ Traumatic Brain Injury
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Brachial Plexus Injury
- ☐ Hemispherectomy
- ☐ Muscular Dystrophy
- ☐ ALS
- ☐ Other: _____

| Date of Injury or Onset of Illness/Symptoms | Is Injury/Illness the Result of an Accident? *(select all that apply)* ☐ Work-related ☐ Auto ☐ Other: | State Where Accident Occurred |
|---|---|---|
| | | |

## EMPLOYMENT INFORMATION *(fill out only if injury/illness was work-related)*

| Name of Employer | Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student ☐ Other |
|---|---|
| | |

## DEVICE INFORMATION

What type of AxioBionics Device are you interested in?

- ☐ Wearable Therapy®
- ☐ WalkAide®/Pace FES
- ☐ TripleFlex™
- ☐ Orthotics

Where did you hear about us?

- ☐ Website (Web Search)
- ☐ Doctor
- ☐ Facebook
- ☐ Therapist
- ☐ Twitter
- ☐ Orthotist/Prosthetist
- ☐ Other:

## EXISTING MEDICAL CONDITIONS

| | | | | | |
|---|---|---|---|---|---|
| Cancer | ☐ YES | ☐ NO | Heart Condition | ☐ YES | ☐ NO |
| In remission? | ☐ YES | ☐ NO | Cardiac Demand Pacemaker | ☐ YES | ☐ NO |
| Seizure Disorder | ☐ YES | ☐ NO | Manufacturer: | Model: | |
| On Anti-seizure Medications? | ☐ YES | ☐ NO | Phone: | | |
| Seizures under control? | ☐ YES | ☐ NO | Cardiac Defibrillator | ☐ YES | ☐ NO |
| Brain Impairments | ☐ YES | ☐ NO | Manufacturer: | Model: | |
| Varicose Veins | ☐ YES | ☐ NO | Phone: | | |
| Allergies to Adhesives | ☐ YES | ☐ NO | Metal Implants in the body | ☐ YES | ☐ NO |
| Blood Clots | ☐ YES | ☐ NO | Location: | | |
| Diabetes | ☐ YES | ☐ NO | Other Medical Conditions | ☐ YES | ☐ NO |

Describe all conditions for which you checked YES, and any others not listed:

continued on next page

# NEW PATIENT INFORMATION

*This Section is for Office Use:* Date: _____ Patient #: _____

## PRIMARY INSURANCE INFORMATION

I authorize AxioBionics to release any medical or other information about me to my other healthcare providers or any other party for the purposes of treatment, payment, or healthcare operations; to my insurance company, health benefit plan, federal health benefits program, third-party payer, third-party administrator, or any other party, including any billing and/or collection service utilized by AxioBionics, necessary to process an insurance claim and/or to invoice and collect payment for items/services provided by AxioBionics and to release any medical or other information about me to auditors authorized by AxioBionics for the purpose of certification, licensure and accreditation, audit and/or review. I permit a copy of this authorization to be used in place of the original. I further authorize AxioBionics to contact me via telephone regarding services to be provided to me.

## ASSIGNMENT OF INSURANCE BENEFITS

I certify that the information given by me is correct. I request that payment for authorized benefits are made on my behalf, I assign the benefits payable for covered services rendered by AxioBionics and authorize AxioBionics to submit claims to Medicare, Medicaid and/or commercial insurance carries, other third-party payers, and administrators for payment. I authorize payment of my benefits directly to AxioBionics.

## PAYMENT POLICY AND RESPONSIBILITY FOR PAYMENT

I understand that it is my responsibility to know my insurance benefits and coverage for all durable medical equipment, supplies and services provided to me by AxioBionics. I understand that AxioBionics, as a courtesy to me, will make every reasonable effort to bill all of my insurance companies for payment of my account. I understand that my insurance does not pay for everything and may not pay for the services or products (including durable medical equipment supplies) provided by AxioBionics. I understand that any remaining balance is my responsibility. I further agree to be personally and fully responsible for all items and services provided by AxioBionics that my insurance will not pay for and any deductibles and/or co-payments to the fullest extent allowed by law and my health benefits plan. If AxioBionics determines that insurance coverage is not available, I understand I that am responsible for all costs.

In the event that I fail to make a payment for which I am personally liable within thirty (30) days after invoice from AxioBionics, I understand that AxioBionics will charge interest on the outstanding balance at the rate of 1.5% per month until the outstanding balance is paid in full. I understand that payment may be made by cash, check, Visa, MasterCard, or American Express and I am responsible for making payment arrangements with AxioBionics if payment cannot be made in full upon receipt of the invoice. I further agree that in the event that any account is placed with an outside collection agency due to nonpayment, I will be responsible for any collection fees that may be added to my outstanding balance. I also understand that a $135.00 office visit charge will be added to my account should I decide to cancel a service/device after casts, molds, or measurements have been made. I agree to pay this charge in the event it is incurred.

I understand that the products made by AxioBionics are custom-made or custom-fit and include a significant degree of professional service that render the products non-returnable. I understand that all sales are final and no refunds will be issued for any reason. Fitting devices such as prosthetics, orthotics, and neuroprosthetic devices to the human body may require making adjustments on an individual basis to ensure proper fit, maximize benefit and function, and ensure safety of use. AxioBionics is committed to this process and, as such, adjustments to fit and performance are included in the AxioBionics one-year warranty.

## PATIENT ACKNOWLEDGEMENTS

1. I certify that I have received a copy of the AxioBionics Privacy Practices.
2. I am aware that I have a condition which requires orthotic and/or prosthetic treatment by AxioBionics. I understand that my physician has ordered this item/service as part of my treatment and that I am under his/her supervision.
3. I am also aware and acknowledge that representatives of AxioBionics have made no guarantees to me regarding the results of any examination or treatment.
4. I understand that multiple visits may be required to achieve proper fit and/or desired results.
5. I have read this authorization form, or it has been read to me, and I understand its contents and agree to its terms.
6. I have completed this form fully and accurately, and have been given the opportunity to ask questions about this form and the services and products that may be provided.
7. I am competent and able to make decisions concerning the services and products that may be provided.

| | | |
|---|---|---|
| Patient's Signature | Print Name | Date |
| Authorized Representative's Signature | Print Name | Date |
| Authorized Representative's Relationship to Patient: | | |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 800-552-3539.

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of AxioBionics.

_____

Please print your name here

_____ _____

Signature of Patient or Legal Representative Date

## AUTHORIZATION TO OBTAIN MEDICAL HISTORY

By signing below, I give permission for AxioBionics to access my medical history. This consent will enable AxioBionics to:

1. Process medical billing to your insurance company or other third party payer (in paper format).
2. Communicate with your primary care physician or other medical specialists to obtain the necessary medical information to manage your case.
3. Place orders on your behalf for items and products from other vendors and specialists.
4. Communicate with your attorney, our attorney, or other legal representatives in order to adjudicate your claim.

In summary, we ask your permission to obtain medical information to properly care for you and to bill for AxioBionics products and services.

_____

Please print your name here

_____ _____

Signature of Patient or Legal Representative Date

Effective Date of this Notice: February 14, 2019

AxioBionics
6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
Phone 800-552-3539 • FAX 888-574-6888

## NOTICE OF PRIVACY PRACTICES

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

Your medical information is personal and AxioBionics is committed to protecting your privacy. We are obligated by law to protect your privacy and give you notice of our privacy practices. This Notice describes how we protect your protected health information and what rights you have regarding your protected health information. “Protected health information” (PHI) means any of your written and oral health information, including demographic data that can be used to identify you. AxioBionics will abide by and act in accordance with the terms of this Notice. Additionally, AxioBionics will notify you if there has been a breach of your unsecured protected health information. If you have any questions, please contact AxioBionics’ Privacy Officer at 800-552-3539.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your protected health information that AxioBionics has created or maintained and for any generated in the future. AxioBionics will have copies of our current Notice in our office and this will also be posted on our website, you may request a paper copy of our most current Notice at any time.

## HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the ways in which we may use and disclose your protected health information. AxioBionics may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless AxioBionics has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all of the ways we are permitted to use and disclose your protected health information will fit within one of these general categories.

### TREATMENT

AxioBionics may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, referring you to other medical professionals, or obtaining copies of information from other health care providers to facilitate your treatment.

Effective Date of this Notice: February 14, 2019

PAYMENT

AxioBionics may use and disclose your protected health information in order to bill and collect payment for services. We may disclose your protected health information to a health care plan to determine eligibility or plan responsibilities for benefits, confirm enrollment and coverage, facilitate payment for treatment and covered services received, coordinate benefits with other insurance carriers, and adjudicate benefit claims and appeals.

HEALTH CARE OPERATIONS

AxioBionics may use or disclose your health information to conduct our business. This may involve disclosures of information for quality assessment and improvement activities, data aggregation services, care coordination, and case management. Other examples include business planning and administrative activities. We will not sell any of your health information unless we have received your express written authorization.

## OTHER DISCLOSURES SPECIFIED BY HIPAA WHICH DO NOT REQUIRE YOUR AUTHORIZATION

DISCLOSURES REQUIRED BY LAW

AxioBionics will use and disclose your protected health information when we are required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

HEALTH OVERSIGHT ACTIVITIES

AxioBionics may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

LAWSUITS AND SIMILAR PROCEEDINGS

If you are involved in a lawsuit or similar proceeding, we may use and disclose your protected health information in response to an order of a court or administrative order or in response to a signed authorization.

LAW ENFORCEMENT AND/OR NATIONAL SECURITY

We may disclose your protected health information for law enforcement purposes. For example, in limited circumstances we may disclose your protected health information if you are a victim of a crime. We may provide information about a crime at AxioBionics, or to report a crime that happened elsewhere. Additionally, we may disclose your protected health information for the purpose of identifying or locating a suspect, material witness or missing person. Further, we may disclose your protected health information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

Effective Date of this Notice: February 14, 2019

DECEASED PATIENTS

AxioBionics may release protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

RESEARCH

Under certain circumstances, we may use and disclose your protected health information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

SERIOUS THREATS TO HEALTH OR SAFETY

AxioBionics may use and disclose your protected health information to prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

## USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION BUT WITH OPPORTUNITY TO OBJECT

COMMUNICATION WITH FAMILY

Occasionally, our staff may discuss particular diseases and their inheritance patterns with you or your family members, if you agree.

Other uses and disclosures of your protected health information not covered by this Notice will be made only with your written authorization. If you provide us with such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights with respect to your protected health information:

CONFIDENTIAL COMMUNICATIONS

You have the right to request confidential communications from us. Upon receiving a reasonable written request from you for confidential communications we will communicate your protected health information by an alternative method or to an alternative location.

RIGHT TO OPT OUT

You have a right to opt out of receiving any fund raising notices from AxioBionics.

REQUESTING RESTRICTIONS

You have the right to request a restriction in our use or disclosure of your protected health information for the purposes of treatment (except in emergencies or when required by law), payment or health care operations. We are not required to agree to your request except as described below; if we do agree, we

are bound by our agreement except in cases of an emergency or in cases where we are legally required or allowed to make a use or disclosure. We are obligated to comply with a request to restrict disclosure to a health plan if the disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law and you have paid AxioBionics in full for the services AxioBionics has provided. To request a restriction on the disclosure of your protected health information you must make your request in writing to the Privacy Officer listed on page one.

## INSPECTION AND COPIES

You have a right to request a copy of your protected health information. You must submit your request in writing to the Privacy Officer listed on page one. AxioBionics may charge a reasonable fee for the costs of copying and mailing your information.

## AMENDMENT

If you feel that protected health information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the Privacy Officer listed on page one. We may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the protected health information which you would be permitted to see and copy, or if it was not created by us.

## LIST OF DISCLOSURES

You have the right to request an accounting of disclosures AxioBionics has made of your protected health information for non-treatment, non-payment or non-operations purposes. Use of your protected health information by AxioBionics for purposes of treatment, payment or operations is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing to the Privacy Officer listed on page one. All requests for disclosures must identify a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional accounting requests may be subject to a reasonable cost based fee.

## RIGHT TO NOTICE

You have the right to receive notice and AxioBionics will notify you if there has been a breach of your unsecured protected health information.

## RIGHT TO A PAPER COPY OF THIS NOTICE

You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, write to the Privacy Officer listed on page one of this notice.

## RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer for AxioBionics or with the Secretary of the Department of Health and Human Services. To file a complaint with AxioBionics, write to the Privacy Officer listed on page one. AxioBionics will not retaliate against you in any way for submitting a complaint.

Effective Date of this Notice: February 14, 2019

6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

# APPEALS AUTHORIZATION

I, _____ (patient/guardian), grant AxioBionics, LLC authorization from this day forward to represent me in the appeals process with my insurance company or any third-party entity for any denial received for AxioBionics products and services.

| | | |
|---|---|---|
| Authorized Representative (print) | Signature | Date |
| Patient Name (print) | Signature | Date |

Street Address

| | | |
|---|---|---|
| City | State | Zip Code |

Country: ☐ United States

Country

| | |
|---|---|
| Email | Phone |

6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

# PATIENT CASE STUDY RELEASE FORM

Patient Name (print) _____ Authorized Representative (print) _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Street Address _____

City _____ State _____ Zip Code _____

Country: ☐ United States Country _____

Email _____ Phone _____

## PERMISSION TO RELEASE INFORMATION INCLUDING PHOTOGRAPHS, VIDEOS, ELECTRONIC OR OTHER MEDIA

I give AxioBionics, LLC and agents acting on its behalf permission to use certain information about the above-mentioned patient for the purposes of education, public relations, marketing, and promotion of AxioBionics and its pain management and neuromuscular stimulation Wearable Therapy® Systems and TripleFlex™ Orthoses. This may include photographs, video, audio, testimony, name, medical case history and results/outcomes. The items may be used by AxioBionics and by the media indefinitely. I understand that I can revoke this permission at any time by contacting AxioBionics at 800-552-3539. However, I also understand that AxioBionics has no control over disclosures made before I revoke my permission.

I understand that the released items will be used in various advertising and educational ventures such as seminars, training materials, the AxioBionics website, social media sites, email correspondence, advertisements, printed promotional literature, shared with news media for publication and/or broadcast and/or distribution via other means to the general public. I release AxioBionics, its agents and employees from liability for any and all claims by me or any third party in connection with my participation. I acknowledge that since my participation is voluntary, I will receive no financial compensation. I further agree that my participation confers upon me no rights of ownership whatsoever and the items may be destroyed at any time.

I understand that I may refuse consent and that this decision will not affect the patient's care.

The following information may be released: *(please check all that you agree to)*

☐ Photos ☐ Video ☐ Audio ☐ Testimony ☐ First Name ☐ Last Name ☐ Case History

Patient or Authorized Representative (print) _____ Signature _____ Date _____

6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

PERMISSION TO USE CLINICAL DATA FROM YOUR MEDICAL CHART FOR RETROSPECTIVE ANALYSIS TO IMPROVE FUTURE CLINICAL CARE AND PRODUCT DESIGN

AxioBionics understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information (PHI) for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. If you have any questions you may ask them now or at any time in the future.

In order to continually improve our devices and increase the number of patients we can help, AxioBionics is constantly monitoring our patients' health data and applying that data to further our understanding of our devices' safety and effectiveness. The information that will be collected during your treatment will be kept confidential. Data used for any studies will be kept anonymous. Any information that could potentially identify you as an individual will be protected and will not be shared with or given to anyone outside of AxioBionics.

I release AxioBionics, its agents and employees from liability for any and all claims by me or any third party in connection with my participation. I acknowledge that since my participation is voluntary, I will receive no financial compensation.

I understand that I may refuse consent to the use of my data and may revoke this permission at any time by contacting AxioBionics at 800-552-3539. However, I also understand that AxioBionics has no control over disclosures made before I revoke my permission. This decision will not affect the patient's care.

| Patient or Authorized Representative (print) | Signature | Date |
|---|---|---|

You have the right to receive a copy of this form after you have signed it.

6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

# CREDIT CARD AUTHORIZATION AND RECURRING PAYMENT FOR PURCHASES FORM

This form grants AxioBionics, LLC authorization to charge the patient's credit card for the indicated service/device. All requested information is required. Upon approval, we will bill your credit card for the amount indicated and your total charges will appear on your credit card statement. Any changes to your credit card information must be communicated to AxioBionics in a timely manner.

Your credit card may be charged for: 1) One-time purchases or trials, 2) Recurring purchases, or 3) Automatic recurring billing for rented or trial equipment.

TERMS OF SERVICE FOR RENTAL, RENT-TO-PURCHASE, AND NON-RETURNABLE ITEMS:
Borrower shall be responsible for proper use of the equipment. Borrower is responsible for the full cost of repair or replacement of any or all equipment that is damaged, lost, or stolen from the time borrower assumes custody until it is returned to AxioBionics. Borrower shall be responsible for the safe packaging and shipping, if needed, of the equipment. If equipment is not returned within 7 days after end date of trial period, borrower shall be charged an additional month of rental. Borrower will incur additional rental charges for each month thereafter until equipment is returned. AxioBionics reserves the right to charge the full purchase price of any equipment not returned. An extension of the trial period must be coordinated with AxioBionics prior to the original end date of the trial period. Equipment shall be returned to: AxioBionics, 6111 Jackson Rd. Suite 200, Ann Arbor, MI 48103.

## PATIENT INFORMATION

Patient Name *(print)* _____ Patient # *(Office Use)* _____

Authorized Representative *(print)* _____ Relationship to Patient _____

## PAYMENT INFORMATION

Service/Device Description _____

Serial # _____ Trial or Rental Start Date _____ Trial or Rental End Date _____

Total Amount _____ Recurring Payment Amount _____

Frequency: ☐ N/A ☐ Monthly ☐ Other: _____

FIRST PAYMENT ON: _____ LAST PAYMENT ON: _____ ☐ No End Date

Start Date *(month/day/year)* _____ End Date *(month/day/year)* _____

## CREDIT CARD INFORMATION

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ American Express ☐ Other: _____

Card Holder's Name *(as shown on card)* _____ Credit Card Billing Zip Code _____

Card Number _____ Expires On *(month/year)* _____ Card Security Code *(CVV)* _____

Card Holder's Email _____ Card Holder's Phone _____

I (patient/authorized representative) grant AxioBionics, LLC authorization bill the credit card listed above as specified.

Patient or Authorized Representative *(print)* _____ Signature _____ Date _____

☐ Verbal Authorization granted by Card Holder

AxioBionics Representative _____ Date _____