IPG
IMPLANTABLE PROVIDER GROUP

Dear Patient:

As you may be aware the Health Insurance Portability and Accountability Act 1996 (HIPAA) standards for privacy of individually identifiable information will affect from April 14, 2003 all disclosures of an individual's health information from Health Care Providers that are covered by the above act.

A Health Care Provider such as your physician or health plan can only share your health information if you have given specific written authorization to the Health Care Provider to do so. This authorization describes how health information from your medical records may be used and disclosed by the Health Care Provider and states the intended use of the information, the people who may use or disclose your health information, the people who will receive your information, the purpose of any use or disclosure of your information and other rights.

As a medical equipment Supplier ("Supplier"), Implantable Provider Group (IPG) uses health information to provide reimbursement services, products and/or devices ("Devices") to be used in your diagnosis and treatment. Some of these Devices may be provided by a Supplier, such as IPG and not by your physician. In order to allow such Devices and services we require you to sign the attached Authorization and Assignment Form.

Please note that this form MUST be signed (and dated/time stamped) before your procedure is done. Otherwise, IPG does not have to accept responsibility for the services/equipment associated with your procedure.

Best Regards,

Implantable Provider Group

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Implantable Provider Group • 2520 Northwinds Parkway, Suite 300 • Alpharetta, Georgia 30009
Toll Free: **1-866-753-0046** • FAX forms to: **1-866-753-0194** • Download forms at www.ipgsurgical.com/forms

Patient Authorization and Assignment

KEEP ON FILE WITH PHYSICIAN/HEALTH CARE PROVIDER

I hereby give my consent to the equipment manufacturer, physician and facility and their representatives to disclose to Implantable Provider Group, Inc. (hereafter referred to as "Supplier") and its representatives, such information about me, for example, my SSN, insurance information & medical information as is reasonably necessary to verify my insurance coverage, review my clinical information, conduct precertification and/or predetermination on my behalf, assist and/or conduct appeals, provide customer service support or provide products and/or devices ("Devices") to be used in your diagnosis and treatment.

Once my health information has been disclosed to Supplier, federal privacy laws may no longer protect the information. However, Supplier agrees to protect this information by using and disclosing it only for the purposes described above or as required by law. Supplier will not further use or disclose my health information, unless information that identifies me directly, such as my name and social security number, is first removed. These limitations continue even after expiration or revocation of the Authorization.

ASSIGNMENT OF INSURANCE BENEFITS. I hereby authorize payment to be made directly to any Supplier that provides Devices ordered by my physician, from any insurance, healthcare benefits or other payor, otherwise payable to me. I understand there is no guarantee of payment from any insurance company or other payor and agree that I am financially responsible for all charges associated with co-payments, deductibles or other coinsurance per allowed amounts, by any insurance company or other payor within a time period the Supplier deems reasonable. I also agree that, in the event that my insurance company issues payment directly to me for services rendered, I will in turn, endorse and forward the full payment amount to the Supplier in exchange for supplies and services utilized during my treatment.

ASSIGNMENT OF CLAIMS. I hereby assign to any Supplier that provides Devices ordered by my physician any and all claims and causes of action against an insurance company or any payor for payment for the Supplier's Devices provided to me. I understand and agree that this assignment takes effect upon notice to me by the Supplier that it intends to exercise these rights. I also understand that this assignment is given to permit the Supplier to pursue these claims on my behalf as a courtesy to me and that the Supplier is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation and agreement to pay the Supplier's charges (not to exceed any co-payments, deductibles or other coinsurance per allowed amounts) for Devices provided to me.

I understand that:

- I may refuse to sign this Authorization, but if I refuse, Supplier will not be able to verify my insurance coverage, review my clinical information, conduct precertification and/or predetermination on my behalf, assist and/or conduct appeals and provide customer service support or provide products and/or Devices;
- My Health Care Provider and Health Insurance Plan will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my agreement to sign this Authorization;
- At any time, I may revoke this Authorization by mailing or faxing a signed letter of revocation to my physician or to the equipment manufacturer, but if I revoke this Authorization, Supplier will be unable to assist my Health Care Provider in obtaining payment for prescribed procedures;
- Revoking this Authorization will prohibit disclosures of information that identifies me after the date my letter of revocation is received and processed by my Health Care Provider and Health Insurance Plan but will not affect Supplier's ability to use and disclose the information they have already received from my Health Care Provider and Health Insurance Plan; and
- I am entitled to a copy of this Authorization.

Signature of Patient or Legal Representative	Relationship to Patient
Print Name of Patient or Legal Representative	Date & Time

Once you have signed the Authorization, please give it to your Physician/Health Care Provider who will then fax to Supplier – You DO NOT need to send it to Supplier.

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