StimRouter®
Neuromodulation System

PATIENT INFORMATION AND MEDICAL RELEASE FORM (FORM I)

PATIENT INFORMATION:			
Patient Legal Name:		Date of Birth:	Gender: ☐Male ☐Female
Address:		City:	
State:	Zip:	Alternate Contact Name and Phone:	
Home Phone:	Work Phone:	Cell Phone:	
Social Security No.:		E-mail Address:	
How did you hear about Bioness?		Primary Diagnosis:	
Can we send a text message?		Cell Phone Carrier:	

PHYSICIAN INFORMATION:		
Physician Name:	Phone:	Fax:
Physician Address:		

FACILITY/CLINICIAN	
Facility Name:	Therapist Name:
Physician Address:	

PRIMARY INSURANCE INFORMATION: (EXACTLY AS INDICATED ON INSURANCE CARD)		
Insurance Company:	State:	☐HMO ☐PPO ☐POS ☐MEDICARE ☐WC
Policy No.:	Group No.:	
Policy Holder Name:	Relation to Patient: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
Customer Service/Claims Phone:	Policy Holder SSN:	Policy Holder DOB:

SECONDARY INSURANCE INFORMATION: (EXACTLY AS INDICATED ON INSURANCE CARD)		
Insurance Company:	State:	☐HMO ☐PPO ☐POS ☐MEDICARE ☐WC
Policy No.:	Group No.:	
Policy Holder Name:	Relation to Patient: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
Customer Service/Claims Phone:	Policy Holder SSN:	Policy Holder DOB:

PATIENT INFORMATION RELEASE AUTHORIZATION AND RESPONSIBILITY ACKNOWLEDGEMENT

Please be aware that all medical information is confidential under certain state and federal laws. Such information may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

I,_____, do hereby authorize Bioness Inc., its parent, or any of its subsidiaries, to acquire from and/or release to my healthcare team and/or my insurance company(s), any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf. I understand that upon acceptance of products from Bioness, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize Bioness to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Bioness. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Bioness. I will be informed of my insurance coverage and estimated out-of-pocket expense prior to any shipment of product or any bills being sent. I have listed all health insurance plans from which I may receive benefits.

I acknowledge that I may view the Medicare Supplier Standards, Bioness Bill of Rights, and the Notice of Privacy Practices online at www.bioness.com or may request a paper copy by calling 800.211.9136 option 2.

Patient/Guardian Signature:_____Date:_____

Patient/Guardian Printed Name:_____

Upon completion, fax this form to Bioness Client Relations Department
Fax: 661.310.9623 | Email: info@bioness.com | Phone: 800.211.9136 option 2

Please Keep for Your Records (for Reference)

I may revoke this consent by mailing or faxing a letter to my healthcare provider or Bioness. Revoking this consent will prohibit my healthcare provider and Bioness from sharing information about me, except where such sharing is permitted or required by law. Revocation will not affect the ability of Bioness or my healthcare provider to use information they have already received. I understand that once released, information may be subject to redisclosure and no longer protected by federal privacy laws. Also, my doctors and insurers cannot condition treatment, payment or enrollment or eligibility for benefits on whether or not I sign this release. This release will expire in 30 years.

Bioness may use my information consistent with its Notice of Privacy Practices, including without limitation, to contact me for customer satisfaction surveys and other marketing communiques and provide me with information and educational materials about Bioness products.

MEDICARE SUPPLIER STANDARDS

I acknowledge that I may view the Medicare Supplier Standards online at www.bioness.com/Medicare_Supplier_Standards.php or may request a paper copy by calling 800.211.9136 option 2.

BIONESS INC NOTICE OF PRIVACY PRACTICES

I acknowledge that I may view the Notice of Privacy Practices online at www.bioness.com/Privacy_Policy.php or may request a paper copy by calling 800.211.9136 option 2.

BIONESS INC RETURN POLICY

If I do not purchase a device I will return it to Bioness in like-new condition, with original packaging and related materials, with prior approval or as dictated on my contract. If I fail to make the return in the agreed time period, or without prior approval, it will constitute my irrevocable election to purchase such device and I hereby authorize Bioness Inc. to charge my credit card or bill me the non-refundable purchase price of each unreturned device, less the Rental and/or Trial as agreed evaluation payment made thereon. If the charge is declined by my credit card company, Bioness may charge my card or bill me a lesser amount and I will be liable for any unpaid portion of the device purchase price. I will pay any costs and expenses incurred by Bioness in connection with collection of any of such amounts and any unpaid portion of the Charge Amount (including without limitation all reasonable attorneys' fees, expenses and all court costs). Bioness is entitled to interest at the highest legal rate on all past due amounts, to the extent permitted by applicable law. All sales are final.

BIONESS INC BILL OF RIGHTS

I acknowledge that I may view the Bioness Inc Bill of Rights online at www.bioness.com/Bill_of_Rights.php or may request a paper copy by calling 800.211.9136 option 2.

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06/2019

StimRouter®
Neuromodulation System

BIONESS STIMROUTER® NEUROMODULATION SYSTEM PHYSICIAN STATEMENT OF MEDICAL NECESSITY/ PRESCRIPTION (FORM II)

ALL SECTIONS MUST BE FILLED OUT COMPLETELY

Patient Legal Name: First	MI.	Last	
Street Address:	City:	State:	Zip:
Patient DOB: MM/DD/YYYY	Phone:		

Initial Order Date:	Revised Order Date:	Renewal Order Date:

☐ StimRouter Neuromodulation System & Supplies (Disposable Electrode Patch changed every 2 to 3 days)

☐ Pain Duration documented as existing longer than 3-months

Primary Diagnosis (mark all that apply):

Pain _____ (ICD-10 code) Pain, not classified _____ (ICD-10 code) Other _____ (ICD-10 code)

Location: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand/Fingers ☐ Unspecified
☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Leg/Thigh

Functional Limitations:

Patient's need (mark all that apply):

☐ Pain Reduction, localized ☐ Improve Functional Capabilities
☐ Reduce dependency on oral medications ☐ Other (explain)

Length of Need:	Prognosis:

PHYSICIAN INFORMATION

Physician:	License #:	NPI #:
Address:	Phone:	Fax:
City, State, Zip:	Office Contact:	
Physician's Signature:	Date:	

State law requires renewal on said item every 12 months. Length of need is dictated based on state standard of 1 year unless indicated above. I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary for this patient's treatment.

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