bioventus®
Innovations For Active Healing

PATIENT INFORMATION AND MEDICAL RELEASE FORM (FORM I)

PATIENT INFORMATION:			
Patient 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.:		Email:	
How did you hear about Bioventus?		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 Bioventus LLC, 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, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize Bioventus to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Bioventus. 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 Bioventus. 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.

☐ By checking this box, I agree to be contacted by Bioventus for the purpose of participating in patient satisfaction surveys. I understand that my participation is voluntary and that I may withdraw my consent at any time by emailing Privacy@Bioventus.com with a request to revoke my consent. Bioventus will handle my personal information in accordance with applicable privacy laws and regulations, including but not limited to HIPAA, CCPA, and other relevant data protection laws.

Patient/Guardian Signature:_____Date:_____

Patient/Guardian Printed Name:_____

Upon completion, fax this form to Bioventus Customer Service Department
Fax: 661.310.9623 | Email: StimRouterPNS@Bioventus.com | Phone: 888.453.2136

Please Keep for Your Records (for Reference)

I may revoke this consent by mailing or faxing a letter to my healthcare provider or Bioventus. Revoking this consent will prohibit my healthcare provider and Bioventus from sharing information about me, except where such sharing is permitted or required by law. Revocation will not affect the ability of Bioventus 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.

If I checked the box on the Release Form, Bioventus 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 to provide me with information and educational materials about Bioventus products.

NOTICE OF PRIVACY POLICY

I acknowledge that I may view the Notice of Privacy Practices online at www.stimrouter.com/privacy-policy or may request a paper copy by calling 888-453-2136.

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