

**PATIENT AGREEMENT- VIVALLY THERAPY PATIENT TO READ & SIGN ON PATIENT AGREEMENT
FORM, PATIENT TO KEEP FOR RECORDS**

*** Indicates a required field**

PATIENT INFORMATION

NAME - FIRST & LAST *	GENDER *	DOB (MM/DD/YYYY) *	
SHIPPING ADDRESS *	CITY *	STATE *	ZIP *
MOBILE PHONE *	EMAIL *		
EMERGENCY PHONE *	EMERGENCY CONTACT *		
PREFERRED WRITTEN LANGUAGE	PREFERRED SPOKEN LANGUAGE		

READ PATIENT AGREEMENT

Section I. Patient Acknowledgement and Consent

1. I acknowledge and agree that my Prescriber has explained the nature of the Vivally System therapy, has evaluated me for the appropriateness of Vivally System therapy, and has determined that the benefits of my use of the Vivally System outweigh the possible harm, and that I have received sufficient information about the appropriate and safe use of Vivally System (including, without limitation, the User Guide to make an informed decision. I hereby authorize Avation Medical (including its personnel and agents) to provide me with the durable medical equipment as prescribed by my Prescriber.
2. Upon receipt of my device, I agree that I shall carefully read the instructions for use, indications for use, contraindications, product warnings and safety statements provided in the User Guide and device packaging/ labelling before using the device (the "Product Labelling"). I agree that I take full responsibility for the safe use and care of the Vivally System and shall only use the Vivally system for its intended purpose and in accordance with my Prescriber's instructions and the Product Labelling. I will not modify, reverse engineer, or otherwise tamper with my Vivally system.

Submit documentation via:



Secure Patient
Fillable Form
Avation.com
Patient Kit



Fax
614.559.6771



PDF
Intake@Avation.com



Avation Medical
PO Box 736474
Chicago, IL
60673-6474



Secure Prescriber
Fillable Form
Avation.com
Prescriber Kit



Call Avation Customer Care at 888.972.5694 for assistance

Avation Customer Care

Phone: 888.972.5694

Fax: 614.559.6771

Email: CustomerCare@Avation.comWeb: Avation.com**Section II. Patient Financial Responsibility Terms****1. Personal Liability for Co-Payments, Deductibles and Insurance Shortfalls.**

I certify that the information I have provided to Avation Medical about my active insurance coverage is correct to the best of my knowledge.

I understand that Avation Medical charges **\$4,995.00** (in-network rate) for the Vivally System (the "Purchase Price"). If Avation Medical is out-of-network with my insurance, I understand that my insurance may not cover any items or services furnished by Avation Medical. My actual out-of-pocket contribution depends on my insurance coverage, co-payments, deductibles, and other factors (e.g., Medicare coinsurance is 20%). I hereby authorize Avation Medical to bill my insurance carrier for the Purchase Price and I agree that I will be responsible for all deductibles, co-payments, co-insurance and/or any amounts not paid by my insurance.

I agree to contact my insurance company for eligibility of benefits and other questions related to my insurance policy and reimbursement. I may also contact Avation Medical at 888.972.5694 or customer-care@avation.com for help understanding my benefits. While Avation Medical will make reasonable efforts to inform me of Avation Medical's estimate of my out-of-pocket expenses, I understand that my insurance company has the ultimate right to determine my coverage, benefits, and reimbursement.

Patient Self-Pay Option: I understand that I have the option to choose to pay for the Vivally System out of my pocket and not involve my insurance company, and I should contact Avation Medical to understand the pricing, payment options, and financial assistance programs that may be available to me. If I elect this patient self-pay option, I agree that the payment terms of Avation Medical's Terms of Use (available at avation.com/terms-of-use) will apply and I authorize Avation Medical (through its payment processors) to charge the payment method that I provide for such purchase.

2. Assignment of Benefits and Rights of Appeal

I authorize Avation Medical to bill my insurance company for the products and services furnished to me by Avation Medical, and I hereby assign to Avation Medical all rights, benefits, and payments to which I am entitled under my benefit plan or insurance for such products and services.

I understand that Avation Medical may work with third party service providers for purposes of processing insurance reimbursement, and I hereby authorize Avation Medical (including its service providers) to act as my authorized representative to interact on my behalf with my insurance company, medical scheme or any other related party, to inquire about, submit claims for, appeal any full or partial denials of payment, and deal with, any issues concerning the payment for Avation Medical's products and services I purchased. I understand that if Avation Medical (including its third-party service providers) files an appeal that I cannot file an appeal on the same issue. I may be required to sign additional authorization forms for the aforementioned purposes.

I may revoke my authorization and appointment at any time by providing writing notice to Avation Medical. I will promptly notify Avation Medical of any changes to my insurance.

Section III. Limited Warranty; Limitations of Liabilities; Return; Disclaimers

1. Limited Warranty; Disclaimers; Limitations of Liabilities: I agree that the Limited Warranty Policy (available at <https://avation.com/limited-warranty>) is incorporated into this Patient Agreement by this reference, which applies to my Vivally System. I understand that individual patient results may vary, and no warranty or guarantee is made regarding my use of the Vivally Systems. Please refer to the Terms of Use (<https://avation.com/terms-of-use>) for the full warranty disclaimers and limitations of liabilities.

2. Return Policy. I will promptly report any malfunctions or defects in my Vivally System to Avation Medical. I understand that I cannot return any component of the Vivally Systems for a refund unless I comply with Avation Medical's return policy, available at <https://avation.com/returns-and-disposal>.

3. Customer Support. I may contact Avation Medical's customer support by calling 888.972.5694 or emailing customercare@avation.com during Monday-Friday 8am - 5pm Eastern time for any product or billing related complaints, concerns, or questions.

4. Adverse Reaction. I shall contact my Prescriber if any treatment reaction or adverse consequences occurs. I shall not hold Avation Medical responsible for any adverse consequences related to any misuse, failure to use, or discontinuation of the treatment. If a treatment reaction occurs when a Prescriber is absent, I will stop using the Vivally System immediately and contact my Prescriber before resuming use.

5. No Medical Advice; Not for Emergencies.

Avation does not offer medical advice or diagnoses, or engage in the practice of medicine. The products and services (offered by Avation Medical) are not intended to be a substitute for professional medical advice, diagnosis, or other treatments recommended by a Prescriber. THE PRODUCTS AND SERVICES SHOULD NEVER BE USED AS A SUBSTITUTE FOR EMERGENCY CARE. IF PATIENT HAS A MEDICAL EMERGENCY, PATIENT SHOULD SEEK EMERGENCY TREATMENT AT THE NEAREST EMERGENCY ROOM OR DIAL 911.

Section IV. Data Privacy and Protection

Authorization. I hereby authorize my Prescriber to disclose my Protected Health Information, as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as described below consistent with this authorization. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will.

Information to be disclosed. I understand and agree that this form authorizes my Prescriber to release my complete medical record, which may include treatment notes, images, test results, and other common medical record documentation made by the physician, nurse, or other ancillary personnel for the entire time I was treated by my Prescriber, as well records related to services rendered or treatments received from my physician(s) or hospital(s) as necessary for Avation Medical to obtain insurance approvals related to my use of the Vivally System. I understand that Protected Health Information may include information that is created both before and after the date of this authorization. I understand that my medical and financial records will be maintained by Avation Medical for a period of time prescribed by state and/or federal law, whichever is longer, and that they are available to me at no cost upon written request.

Non-Protected Health Information. As a condition of creating my Avation Medical mobile app account that is a component of the Vivally System, I shall read and hereby agree to Avation Medical's Privacy Policy (available at avation.com/privacy-policy). Avation Medical's Privacy Policy explains how Avation Medical processes and shares information received from me that is not covered by HIPAA ("Non-PHI").

Persons/organizations authorized to receive and/or use my Protected Health Information. I authorize Avation Medical, its authorized agents, business associates and subcontractors to receive Protected Health Information from my Prescriber and to use or disclose such information for the purposes consistent with this authorization.

(Section IV. continued on next page)

Section IV. Continued

Persons/organizations authorized to receive and/or use my Protected Health Information. I authorize Avation Medical, its authorized agents, business associates and subcontractors to receive Protected Health Information from my Prescriber and to use or disclose such information for the purposes consistent with this authorization.

Purpose of the use or disclosure. I authorize the parties authorized to receive my Protected Health Information consistent with this authorization to use and disclose all, or any part of, the Protected Health Information at my direction and as necessary: (i) for treatment purposes, (ii) for operation purposes, and (iii) to obtain insurance approvals related to my use of the Vivally Systems. These purposes may include enabling and customizing my use of the Products and Services; providing me with alerts regarding the Products and Services; providing me with updates and information about the Products and Services; and supporting, developing, and improving the Products and Services. I also understand that Avation Medical may de-identify, as that term is defined under HIPAA, information disclosed under this authorization, and that once de-identified the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

Revocation. I understand that I may revoke my authorization at any time by sending written notice to Avation Medical at customercare@avation.com. I understand that my revocation will be effective upon receipt and Avation Medical will cease the collection of my Protected Health Information, except to the extent that any party has acted in reliance on this authorization. I understand that I have the right to refuse to sign this authorization. My Revocation of this authorization does not affect Avation Medical's use of my Non-PHI.

Acknowledgments. I acknowledge that I have read and understand this authorization and that I have had an opportunity to discuss it with my Prescriber. I understand that I have a right to receive a copy of this authorization and may send a request for a copy to Avation Medical at customercare@avation.com. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form. I acknowledge that my authorization will remain valid as long as I obtain services from Avation Medical unless earlier revoked by me or as otherwise limited by applicable law. I understand that once information is used or disclosed under this authorization, there is a potential for it to be redisclosed and may no longer be protected under federal or state privacy law. However, I further understand that state law may prohibit the person receiving my information from making future disclosures of my information unless another authorization for disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

I acknowledge that I have been provided with, and have read and understood, the following agreements and notices (collectively, the "**Patient Agreement**"): (i) Patient Agreement attached hereto, which includes Patient Financial Responsibility Terms, User Guide including and Data Privacy and Protection, and (ii) the Terms of Use, PrivacyPolicy, Indications For Use, Limited Warranty, and Return Policy posted on Avation Medical's website at avation.com, which may be amended from time to time and include warranty disclaimers and limitations of liabilities.

AGREED

PATIENT SIGNATURE *	DATE *
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Personal representative: If the individual signing this form is not the patient, please print name and specify relationship to the patient; if Power of Attorney, please provide documentation.

PERSONAL REPRESENTATIVE:	DATE
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