**Patient Financial Responsibility Agreement – Cryoneurolysis with iovera°**

Applicable to the following categories of patients: Patient Pay, Uninsured, Private Insurance, Commercial Insurance

1. **Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder Group/Policy No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Explanation of Services**

You have agreed to receive cryoneurolysis with the iovera° system from a licensed healthcare provider (our practice) to achieve pain relief, through our patient pay program.

iovera° is a handheld device that permits healthcare providers to apply a precise amount of extreme cold to the pain-causing peripheral nerves that they want to target. This treatment stops the sensory nerves from sending pain signals to the brain. The temperature of the iovera treatment is not cold enough to permanently stop the nerve from signaling, so the effect is not permanent. iovera° blocks pain signals until the nerve regenerates and its sensory function is restored. Patients can return to their healthcare provider to receive additional treatments as needed.

Depending on the extent of a patient’s treatment with iovera°, treatment is normally completed in about 30 minutes. First, a numbing agent (topical or injected) is applied to minimize discomfort during treatment. The healthcare provider then inserts a small needle into the patient’s skin to deliver precise, controlled doses of cold directly to the targeted nerves. This treatment is designed to immediately block the nerves from sending pain signals, thereby providing immediate pain relief. The process is complete when the targeted nerves causing pain are blocked. Wait for your healthcare provider to tell you when you can return to your normal activities and/or exercise.

1. **Health Insurance Coverage**

The patient pay program is based on your health insurance policy (if applicable) not including full coverage for the iovera° treatment. For patients with private or commercial health insurance, our practice will first attempt to bill your health insurance company. You will then assume financial responsibility for any remaining balance not covered by your health insurance, including applicable co-payments and/or deductibles for which you are responsible.

Should you wish to appeal or pursue full or partial reimbursement from your health insurance provider after the treatment, then you may pursue this yourself using your patient pay transaction receipt and other signed documentation of the procedure.

1. **Financial Responsibility**

Our practice’s transparent cost for the iovera° treatment is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patients with Private or Commercial Health Insurance: You are financially responsible for all iovera° treatment costs not covered by your health insurance plan, if applicable. These non-refundable costs do not cover additional treatments, or follow-up care.

Patient pay or Uninsured Patients: You are financially responsible for all iovera° treatment costs. These non-refundable costs do not cover additional treatments, or follow-up care.

1. **Payment Terms**

For patient pay or uninsured patients, payment is due in full prior to the delivery of each iovera° treatment. Payments may be charged to your credit card, or by check, cash, HSA card, or FSA card.

For patients with private or commercial health insurance, payment of any outstanding balances not covered by your health insurance plans may be charged to your credit card on file, or by check, cash, HSA card, or FSA card.

1. **Authorization to Bill**

You hereby authorize our practice to first bill your health insurance company (if applicable) for the iovera° treatment(s) delivered, and then bill you for any amounts not covered.

1. **Signature and Date**

You, the undersigned, agree to and acknowledge your understanding of the financial responsibilities outlined in this document for iovera° treatment under our practice’s patient pay program.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_