GAME READY®

Notice of Financial Responsibility

FORM IS NOT REQUIRED FOR WORKERS' COMPENSATION OR ACTIVE DUTY MILITARY

PATIENT INFORMATION:

Name: ______________________________

Address: ______________________________

City: ______________________ State: ____________ Zip: ______________

Date of Birth: ____/_____/_____ (Month/Day/Year) (for Patient identification purposes only)

EXHIBIT A: STATEMENT OF CHARGES

Anticipated charges are as follows:

Daily rental fee	$______/day	
Number of rental days		
Total rental fee (daily rental fee multiplied by number of days)	$_______	Your insurance company may be billed this amount. Actual charges may vary depending upon the number of days the equipment is rented.
Deposit (if applicable)	$_______	This amount is to be paid by you upon delivery of the Product, and will be credited to the outstanding balance. This amount may be reimbursed to you in whole or in part according to the policy outlined below.

NOTE: The above charges may be subject to additional taxes in accordance with your city/state taxes for Durable Medical Equipment. Your local representative can assist you.

PRESCRIBED EQUIPMENT: CoolSystems, Inc., d/b/a Game Ready provides the Game Ready® Injury Treatment System which has been recommended and prescribed for you by your doctor. Accepting the doctor's recommendation is your choice, and by signing this Notice of Financial Responsibility and Assignment of Insurance Benefits, you agree to the terms set forth below.

HEALTH INSURANCE CLAIMS – TERMS & CONDITIONS: If you have insurance, CoolSystems may, at its discretion and as a courtesy to you, bill your insurance carrier for the total costs of renting this Product. Your insurance plan may or may not cover all of the cost of the use of the Product. In the event your insurance pays 100% of the billed charges or if the combined sum of payments made by both the insurance provider and you exceeds 100% of the total billed charges, including the payment of deductibles and share of cost percentages, CoolSystems will refund any such excess amount to you up to the amount previously paid by you. **To the extent your insurance does not pay the charges for your use of the Product, you agree to be personally and fully responsible for payment of the charges set forth above.** You bear ultimate financial responsibility for the charges, including personal injury cases, regardless of the outcome of litigation. In the event that the claim is denied, you agree to pay any unpaid balance, notwithstanding any appeal of such denial.

By signing below, you acknowledge financial responsibility for the rental of the Product and agree to the Terms and Conditions above.

PATIENT SIGNATURE, PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE:

By signing below, I agree to the terms and fees set forth above and authorize CoolSystems, Inc. to charge my credit card for the charges specified above as well as for charges for subsequent services that may be prescribed by my physician.

Patient Signature: ______________________________ Date: ______________

Is patient under the age of 18 or does the patient have a legal guardian? ❑ Yes ❑ No If yes, please complete the following:

Authorized Personal Representative Name (print): ______________________________

Authorized Personal Representative Signature: ______________________ Date: ______________

Authorized Personal Representative Information (required)

Address: ______________________________

City: ______________________ State: ____________ Zip: ______________

Phone: ______________________ Email: ______________________

CoolSystems, Inc. Representative Signature: ______________________ Date: ______________

©2016 CoolSystems, Inc. All rights reserved. 703994-F