GAME READY®

Notice of Financial Responsibility

APPLICABLE FOR CASH, COMMERCIAL, AND AUTO/PI*

PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

STATEMENT OF CHARGES

Anticipated charges are as follows:

Daily rental fee	$_____/day	$60 - Cash / $70 - Commercial and Auto/PI
Number of rental days		
Total rental fee (daily rental fee multiplied by number of days)	$_____	Your insurance company may be billed this amount. (This does not apply to Cash/Self-Pay orders.)
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 (or the undersigned) 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 (or the undersigned) agree to pay any unpaid balance, notwithstanding any appeal of such denial.

By signing below, the patient, the personal representative (if applicable), and the financially responsible party (if applicable), acknowledge financial responsibility for the rental of the Product and agree to the Terms and Conditions above.

PATIENT, PERSONAL REPRESENTATIVE or FINANCIALLY RESPONSIBLE PARTY SIGNATURE:

By signing below, I agree to the terms and fees set forth above and authorize CoolSystems, Inc. d/b/a Game Ready, 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 Name (print): _____

Signature: _____ Date: _____

Is patient under the age of 18, or does the patient have a legal guardian or financially responsible party?

☐ Yes ☐ No If yes, the legal guardian or financially responsible party must complete the following:

By signing below, I agree to the terms and fees set forth above and authorize CoolSystems, Inc. d/b/a Game Ready to charge my credit card for the charges specified above as well as for charges for subsequent services that may be prescribed by the patient's physician.

Authorized Personal Representative or Financially Responsible Party Name (print): _____

Signature: _____ Date: _____

Authorized Personal Representative or Financially Responsible Party Information (required)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

CoolSystems, Inc. Representative Signature: _____ Date: _____

PLEASE SUBMIT CHECK PAYMENTS TO:
CoolSystems, Inc.
P.O. Box 39000
Dept 34678
San Francisco, CA 94139-0001

* Not applicable for LOP or No Fault.

Product Service: 1.888.GameReady (1.888.426.3732) Billing Questions: 1.800.859.8206

Notifier: CoolSystems, Inc. • dba Game Ready® • Concord, CA 94520 • 1.888.426.3732

Patient Name: Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Equipment below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Equipment below.

EQUIPMENT	REASON MEDICARE MAY NOT PAY	ESTIMATED COST
☐ Game Ready® System (cryopneumatic therapy for orthopedic injury/ post-operative recovery)	A unique billing code for this specific product has not yet been assigned by Medicare.	Approximately $70 per day.

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Equipment** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1**. I want the **Equipment** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2**. I want the **Equipment** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- ☐ **OPTION 3**. I don't want the **Equipment** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay**.

ADDITIONAL INFORMATION:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

SIGNATURE:	DATE: