GAME READY®

WELCOME TO GAME READY

Your physician has prescribed the Game Ready® System to you as part of your upcoming recovery from orthopedic surgery or injury. You're in great company. Game Ready is the injury treatment system of choice for thousands of prominent orthopedic clinics, athletic trainers and physical therapy centers. Also, teams and athletes from nearly every professional sport use the Game Ready System for their recovery, including the NFL, NBA, and NHL as well as the U.S. Olympic Committee and elite military operational forces such as the U.S. Navy SEALs.

This kit provides you the forms necessary to rent the Game Ready System based on your physician's recommendation and prescription.

To learn more about the Game Ready Injury Treatment System, Common Questions, Supplier Standards, and the Community Resource Guide, please visit www.gameready.com or call 1.888.GameReady.

For product or troubleshooting help, please call Customer Service 24 hours a day, 7 days a week at 1888.GameReady (1888.426.3732) or, contact your local Game Ready Representative.

NATIONAL ACCREDITATION

Providers of many healthcare services may have National Accreditation that certifies the organization has met specific quality and safety standards of patient care. You may be interested in choosing a care provider with such accreditation. There are a number of such facilities which can be identified for you through the organizations listed below:

The Community Health Accreditation Program, Inc. (CHAP)
1275 K Street NW, Suite 800
Washington, DC 20005
Phone: 1.202.862.3413
Toll-free: 1.800.656.9656
M-F, 8am-5pm EST
www.chapinc.org

The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Customer Service: 1.630.792.5800
Complaints: (toll-free) 1.800.994.6610
www.jointcommission.org

CoolSystems, Inc., maker of Game Ready, is proud to have met the Standards of Excellence established by the Community Health Accreditation Program (CHAP) and has been certified as a nationally accredited community health care provider. Should you have questions or concerns about the quality of your care that Game Ready cannot answer, call CHAP at 1.800.656.9656.

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PATIENT AGREEMENT

PATIENT INFORMATION: (hereinafter "Patient")
Name:______________________________ Phone: ______________
Address: ______________________________
City:______________________ State: __________ Zip: ______________
Date of Birth: __________ (Month/Day/Year) (for Patient identification purposes only)
E-Mail Address: ______________________ Delivery Comments: ______________

EMERGENCY CONTACT:
Name:______________________________ Phone: ______________
☐ Patient declined to provide emergency contact. (check if applicable)

PRESCRIBED EQUIPMENT. CoolSystems, Inc., d/b/a Game Ready provides the Game Ready® System which has been recommended and prescribed for the Patient by his/her doctor. Accepting the doctor's recommendation is the Patient's choice, and by signing this Agreement, s/he agrees to the terms set forth below.

CHARGES. All patients, except those whose claims were previously authorized by their insurance carriers, will be billed for the rental equipment while it is in his/her possession. As detailed in the Notice of Financial Responsibility, CoolSystems may elect to bill Patient's insurance plan as a courtesy to the Patient. In the event Patient's insurance plan does not pay CoolSystems in full, Patient will be financially responsible for all unpaid balances, including applicable sales tax, co-payments and deductibles, less any deposit paid, and will pay such amounts within thirty (30) days of notice from CoolSystems. Interest shall accrue at twelve percent (12%) or the highest lawful rate, whichever is greater, on any delinquent payment from the date when such payment was due until paid in full.

HEALTH INSURANCE BILLING AND ASSIGNMENT OF BENEFITS. Patient hereby certifies that the information given to CoolSystems in applying for the Product rental is true and correct. Patient authorizes CoolSystems or its designee to bill any third party payors and request that payment of authorized benefits be made directly to CoolSystems or its designee on your behalf. This assignment of benefits is valid for all insurance companies and programs. Additionally, patient authorizes CoolSystems to file an appeal as may be required in the event of patient's health insurance plan's initial or subsequent claims denial and/or benefit determination.

RENTAL PERIOD. Patient understands that the equipment is rented on a daily basis. Daily charges will stop accruing on the earlier of the end of the prescribed use period, the pick-up date listed on this agreement, or the day CoolSystems receives a call requesting pick-up of the equipment/accessories. Rental period may be extended in one-day increments by written authorization of your doctor, and all extensions shall be subject to the terms of this Agreement.

OWNERSHIP. CoolSystems shall at all times retain ownership and title of the rental equipment. Patient will give CoolSystems immediate notice in the event that any of said equipment is levied upon (seized) or is threatened with seizure, and Patient shall indemnify (protect) CoolSystems against all loss and damages caused by such action.

RISK OF LOSS. CoolSystems shall not be responsible for loss or damage to property, material, or equipment belonging to Patient, his/her agents, employees, guests, suppliers, or anyone directly or indirectly affiliated with Patient while said material property, or equipment is in the Patient's care, custody, and/or control.

RECALL NOTICE. CoolSystems may recall any or all equipment upon five (5) business days written notice to Patient.

INDEMNIFICATION. Patient agrees to protect, indemnify and hold harmless CoolSystems, its officers, directors, employees and agents from and against all claims, damages and costs, including legal expenses, arising out of Patient's use of the rental equipment.

ACKNOWLEDGEMENT OF USE INSTRUCTIONS. Patient acknowledges that s/he has been instructed on how to use the equipment either (1) in person by a CoolSystems Representative or (2) on the telephone with Game Ready Patient Care. Patient takes full responsibility for the proper use and care of the equipment.

ACKNOWLEDGEMENT OF PATIENT ORIENTATION CHECKLIST. Patient acknowledges that s/he is responsible for providing the signed Patient Orientation Checklist (POCL) to CoolSystems before using the rental equipment.

MAINTENANCE AND OPERATION. Patient shall not remove, alter, disfigure or cover up any numbering, lettering, or insignia displayed upon the equipment, and shall see that the equipment is not subjected to careless, unusually or needlessly rough usage. Patient shall maintain the rental equipment in good repair and operative condition, and return it in such condition to CoolSystems. Ordinary wear and tear resulting from proper use thereof alone is routine and expected.

(AGREEMENT CONTINUED ON BACK PAGE)

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NO SUBLETTING/ASSIGNMENT. Patient shall not sublet the rental equipment and shall not assign or transfer any interest in this Agreement without the express prior written consent of CoolSystems. CoolSystems may assign this Agreement without notice. Subject to the foregoing, this Agreement accrues to the benefit of, and is binding upon, the heirs, successors, and assigns of the parties to this Agreement.

MISCELLANEOUS. This medical device is provided to Patient on the orders of a physician's prescription. The patient is responsible for using the equipment for the purpose for which it was prescribed and only for whom it was prescribed. The Patient is responsible for notifying CoolSystems immediately of (1) any address or telephone change whether permanent or temporary, (2) any changes in or loss of insurance coverage or of any changes in his/her physician, or (3) any equipment failure, defect or damage. The Patient is responsible for any incidental or consequential cost of repair caused by the delay or failure to notify CoolSystems when equipment attention is needed.

RETURN OF RENTAL UNIT. The Patient is responsible for arranging the return of the medical device in the same condition in which it was received (excluding normal wear and tear) to CoolSystems. Any missing or damaged parts and/or entire medical device (if not returned or damaged beyond repair) will be billed to the Patient. The costs of individual components, repair costs, and/or the entire device will be determined by the current price list in effect at the time of discovery.

PATIENT ACKNOWLEDGEMENT: This agreement consists of all of the terms and conditions on this and the reverse side of this page, whether written or printed. I certify that I have read the terms and conditions of this Agreement and agree to be bound by such provisions. I accept full responsibility for all services rendered, including being informed of my rights, responsibilities, and the complaint procedures. I will receive instruction on the safe and proper use of the equipment and/or accessories and/or supplies provided and agree to notify CoolSystems immediately when medical necessity for the product has ended. I have received a copy of the Authorization and Release of Medical Information, the Notice of Privacy Practices, and the Patient Bill of Rights. I acknowledge that this agreement covers the initial rental period identified above and any and all rental extension periods based upon a physician's prescription providing for such rental extension.

PATIENT SIGNATURE, PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE:

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): ______________________ Relationship to Patient: ______________

Authorized Personal Representative Signature: ______________________ Date: ______________

TO BE COMPLETED BY GAME READY REPRESENTATIVE:

EQUIPMENT AND ACCESSORIES:

GAME READY RENTAL UNIT Unit Serial Number: ______________________

Start Date: ____________ Stop Date: ____________ Number of Weeks: ________

- ☐ Ankle ☐ L ☐ XL
- ☐ Articulated Knee
- ☐ Back
- ☐ C-T Spine
- ☐ Cooling Vest
- ☐ Cryo Cap
- ☐ Elbow
- ☐ Flexed Elbow
- ☐ Half Leg Boot
- ☐ Full Leg Boot ☐ M ☐ L
- ☐ Hand/Wrist
- ☐ Hip/Groin ☐ Left ☐ Right
- ☐ Knee
- ☐ Shoulder ☐ Left ☐ Right | ☐ M ☐ L

TRAUMATIC AMPUTEE

- ☐ Above-the-Knee ☐ Left ☐ Right
- ☐ Below-the-Knee
- ☐ Utility

PAYMENT TYPE: ☐ Private Insurance ☐ Patient Self Pay ☐ Worker's Compensation ☐ No Fault Auto ☐ TriCARE Active Duty Military ☐ Veterans Affairs ☐ Demo

CoolSystems, Inc. Representative Signature: ______________________ Date: ______________

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AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION, NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

The following document contains important information about how we treat your medical and healthcare information and your rights as a client or patient. Please read this carefully.

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION: You hereby authorize CoolSystems, Inc. and/or any holder of medical information about you to release to third party payers, insurance companies, health insurance insurers, or medical necessity/utilization review organizations, any information needed to determine payment of authorized benefits until all outstanding charges for you associated with CoolSystems equipment/accessories have been paid. You further agree that CoolSystems, its employees, agents, representatives, Business Associates, and accrediting and governmental agencies may access, request, and receive from healthcare providers involved in your care, and use or disclose your medical information for the purposes of providing CoolSystems equipment/accessories, obtaining/substantiating payment for equipment/accessories, and administering its own business operations, in accordance with the Health Insuranvce Portability and Accountability Act (HIPAA) of 1996, as amended.

PATIENT SIGNATURE, PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE:

Name: ______________________________

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): ______________________ Relationship to Patient: ______________

Authorized Personal Representative Signature: ______________________ Date: ______________

CoolSystems, Inc. Representative Signature: ______________________ Date: ______________

NOTICE OF PRIVACY PRACTICES

CoolSystems is committed to protecting your privacy and has developed policies and procedures to ensure that the information you provide to us is collected and maintained in a confidential manner. This Notice of Privacy Practices describes how we collect, use and disclose the information you provide to us and your rights with respect to that information.

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE USE OR DISCLOSE YOUR HEALTH INFORMATION

1. For Health Care Operations. Your health information may be disclosed to employees or business associates of the company when needed to provide you with products and/or services, to secure payment for products and/or services provided, and as needed to operate our business. Employees and business associates of the company will only be provided with the minimum necessary information needed to complete their duties.

2. For Treatment. Your health information may be disclosed to other healthcare professionals for the purpose of providing you with quality healthcare.

3. For Payment. Your health information may be disclosed to your insurance provider for the purpose of the company receiving payment for providing you with needed healthcare products and services.

4. For Reminders. Your health information may be used or disclosed to contact you to remind you of the need to re-order regular and routine supplies that you currently receive from the company, or to notify you of other health services that may be of interest to you.

5. As Required by Law. We may use or disclose your health information when required to do so by federal, state or local law.

6. To Persons Involved With Your Care. Your health information may be disclosed to a person involved in your care or who helps pay for your care, such as a family member, provided you agree to this disclosure or we give you an opportunity to object to the disclosure. If you are unavailable or unable to object, we will use our best judgment to decide whether this disclosure is in your best interests.

7. To Avoid a Serious Threat to Health or Safety. Your health information may be disclosed when necessary to avoid a serious threat to your health and safety or the health and safety of the public or another person.

8. Public Health Activities. Your health information may be released to a public health organization or federal organization in the event of the need to report a communicable disease or to report a defective device.

9. For Health Oversight Activities. Your health information may be disclosed to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

10. Judicial or Administrative Proceedings. Your health information may be disclosed in response to a court or administrative order if you are involved in a lawsuit. We may also disclose your confidential health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice) or to obtain an order protecting the information requested.

11. Specialized Government Functions. Your health information may be disclosed for specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

12. Law Enforcement Purposes. Your health information may be disclosed to law enforcement officials for purposes such as providing limited information to locate a missing person or report a crime

(NOTICE CONTINUED ON BACK PAGE)

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13. For Reporting Victims of Abuse. Your health information may be disclosed to government authorities that are authorized by law to receive information about victims of abuse, crime, or domestic violence, including a social service or protective service agency.

14. Worker's Compensation. Your health information may be disclosed for workers compensation, as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

15. Business Associates. Your health information may be disclosed to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of February 17, 2010, our business associates also will be directly subject to federal privacy laws.

16. Data Breach Notification. Your contact information may be used to provide notices of unauthorized acquisition, access, or disclosure of your health information as required by law.

17. Personal Representatives. Your health information may be disclosed to you or a person who is legally authorized to act for you such as a parent, legal guardian, administrator or executor of your estate, or individual authorized under applicable law.

18. Your health information may not be disclosed for any other purpose than that which is described in this notice without requesting a specific written authorization from you to disclose information for a specific purpose. If you give us authorization to disclose your confidential health information, you may revoke (cancel) your authorization in writing at any time, except if we have already acted based on your authorization. To revoke an authorization, send a written notice to Game Ready, Attn: Reimbursement Manager, 1800 Sutter Street, Suite 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION IN OUR RECORDS

1. You have the right to restrict uses or disclosures of your information for treatment, payment or health care operations. You also have the right to restrict disclosures to family members or someone who is involved in your health care or payment for your health care. Please note that we are not required to agree to your request. If we agree, we will comply with your request except in certain emergency situations or as required by law.

2. You have the right to request that we not send health information to health plans in certain circumstances if the health information concerns a health care item or service for which you have paid us out of pocket in full.

3. You have the right to receive confidential communications about your health status and the products and services provided to you in an alternative manner or location (e.g., requesting information be sent to a post office box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept requests to receive confidential communications, modify or cancel a previous confidential communication and the request must be made in writing. You can mail your request to the address listed below.

4. You have the right to review and obtain a copy of health information that may be used to make decisions about you such as medical records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. You can mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information, in which case, you may request that the denial be reviewed. We may charge a reasonable fee for any copies.

5. You have the right to request that we amend health information that we maintain about you if it is incorrect or incomplete. Your request must be in writing and provide the reasons for the requested amendment. If we deny your request, you may have a statement of your disagreement added to your health information. You can mail your request to the address listed below.

6. You have the right to receive an accounting of certain disclosures of your health information. This is a list of the disclosures made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.

7. You have the right to receive a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

The Company will abide by the terms of this notice. The Company reserves the right to make changes to this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and any information we receive in the future. Patients will receive a mailed copy of any material changes to this notice within 60 days of making the changes.

SUBMITTING A WRITTEN REQUEST

Mail to us your written requests for: (i) confidential communications or to modify or cancel a prior confidential communication request; (ii) copies of your records, or (iii) for amendments to your record, at the following address: Game Ready, Attn: Reimbursement Manager, 1800 Sutter Street, Suite 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206.

FOR MORE INFORMATION OR TO REPORT A COMPLAINT

If you have questions about this notice or want to exercise any of your rights please contact: Game Ready, Attn: Reimbursement Manager, 1800 Sutter Street, Suite 500, Concord, CA 94520 or call during normal business hours at 1.800.859.8206.

You may file a complaint with the Company if you believe your privacy rights have been violated and there will be no retaliation. To file your complaint, please mail it directly to the Company at the following address: Game Ready, Attn: Privacy Officer, 1800 Sutter Street, Suite 500, Concord, CA 94520. All complaints will be investigated.

If you have questions or concerns that CoolSystems could not resolve, you may also call the Community Health Accreditation Program (CHAP) at 1.800.656.9656, M-F, 8am-5pm EST.

Attention Florida Residents (only): To report a complaint regarding the services you receive, please call the Florida Agency for Healthcare Administration (AHCA) toll-free at 1.888.419.3456. To report abuse, neglect, or exploitation of a disabled adult or an elderly person, please call the Florida Abuse Hotline toll-free at 1.800.962.2873.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

CLIENT/PATIENT BILL OF RIGHTS

As a client/patient, you have the right to:

1. Access to homecare equipment and services regardless of your race, creed, religion, sex, or source of payment.
2. Request and receive an itemized, detailed explanation of your bill for equipment and services.
3. Be allowed reasonable participation in decisions regarding your homecare services.
4. Be communicated with in a way that you can reasonably understand.
5. Refuse treatment (as permitted by law). If you refuse treatment, you have the right to be informed of the medical consequences.
6. Choose your provider of homecare services and/or receive our assistance in finding and transferring your homecare services to another provider.
7. Receive homecare services in a timely manner, appropriate for your needs, and have competent and qualified people carry out such services.
8. Be treated with respect and consideration, to be assured of confidentiality in your treatment, and records of your treatment.

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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.
TOTAL AMOUNT DUE	$__________	**PLEASE SUBMIT CHECK PAYMENTS TO:** CoolSystems, Inc. P.O. Box 39000 Dept 34678 San Francisco, CA 94139-0001

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.

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 Game Ready to charge my credit card for the charges specified above.

Card Type (choose one): ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover Last 4 Digits of Card Number: ______________

Authorized Personal Representative/ Financially Responsible Party/ Cardholder Name (print): ______________________________

Signature: ______________________________ Relationship to Patient: ______________ Date: ______________

Authorized Personal Representative/ Financially Responsible Party/ Cardholder Information (required)

Address: ______________________________

City: ______________________________ State: ______________ Zip:

Phone: ______________________________ Email: ______________________________

CoolSystems, Inc. Representative Signature: ______________________________ Date: ______________

* Not applicable for LOP or No Fault

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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.
☐ **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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

You are required to complete and submit the Patient Orientation Checklist once you have received your Game Ready System and concluded your training. You must submit the completed form to Game Ready Patient Care (or an authorized representative) before beginning your therapy. You may submit your completed Patient Orientation Checklist the following ways:

DOCUSIGN
Complete the form on the following page and click Finished to submit to Patient Care

EMAIL
Email a scanned / photographed copy of the completed form to patientcare@gameready.com

NEED HELP?
Call a Patient Care Specialist at

1.800.859.8206

For troubleshooting or technical support, please call Customer Service at

1.888.426.3732, Option 3

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PATIENT ORIENTATION CHECKLIST

PATIENT INFORMATION: (hereinafter "Patient")
Name: ______________________________

SYSTEM INFORMATION:
RENTAL UNIT Serial Number: ______________________________

You **must** call Game Ready Patient Care at **1.800.859.8206** to confirm the following before using the equipment*:

Initial	PATIENT CONFIRMATION OF RECEIPT OF EQUIPMENT AND DOCUMENTATION
	Patient received Game Ready System per prescription including Control Unit, Wrap(s), and User Manual. **IMPORTANT: If you have not received a User Manual, STOP and call Customer Service at 1.888.426.3732, Option 3.**
	Patient confirmed a clear understanding of health care practitioner's prescribed use of the Game Ready System. (i.e. the prescription Rx)
	Patient received information on and understands the contraindications associated with use of System. (*The contraindications may be found in the User Manual and the Wrap Use Guide.*)
	Patient received information on and understands the general warnings and cautions associated with the use of the System. (*The general warnings and cautions may be found in the User Manual and the Wrap Use Guide.*)

Initial	PATIENT CONFIRMATION OF USE INSTRUCTIONS
	Patient understands and demonstrates safe placement of the Game Ready System.
	Patient understands the setup process, including filling the reservoir with water and ice.
	Patient understands and demonstrates safe operation of the Game Ready System.
	Patient understands how to properly adjust the User Interface settings to those prescribed by the health care practitioner.
	Patient understands and demonstrates proper application/connection of the Wrap and Connector Hose.
	Patient understands and demonstrates proper care of all components, including, but not limited to the Control Unit, the Wrap, the connector hose, and the AC adapter and power cord. (*Care instructions may be found in the User Manual.*)
	Patient understands how to properly clean the Game Ready System.

PATIENT ACKNOWLEDGEMENT: I acknowledge that all of the above are true to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________

PERSONAL REPRESENTATIVE or RESPONSIBLE PARTY SIGNATURE: (use if Patient has a legal guardian or is under the age of 18)

Authorized Personal Representative Name (print): ______________________________ Relationship to Patient: ______________

Authorized Personal Representative Signature: ______________________________ Date: ______________

(Signature required below only if training was provided in person or via the telephone by a CoolSystems, Inc. Representative):

CoolSystems, Inc. Representative Signature: ______________________________ Date: ______________

* If an authorized Game Ready Representative is providing your In-Service in person, you do not need to call Patient Care. Please provide this completed and signed form directly to them.

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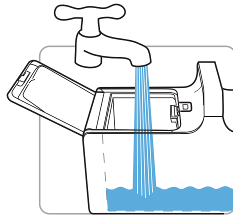
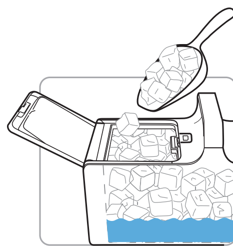
GRPRO® 2.1
QUICK START

1 FILL RESERVOIR



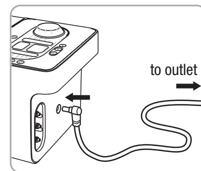
Add water to the reservoir fill-line.
DO NOT OVERFILL.

2 ADD ICE



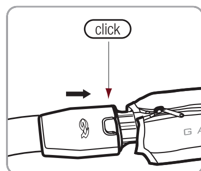
Add it to top of reservoir.
Replenish the ice as necessary.

3 CONNECT POWER



Connect AC Adapter to the receptacle on the end of the Control Unit, then plug the AC Adapter into an electrical outlet

4 CONNECT WRAP



Connect Hose to Wrap, then to Control Unit. Apply Wrap.

5 PRESS POWER

6 CHOOSE MODE

a) PROGRAM *or* **b)** MANUAL

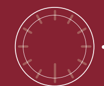
Push Program button for Program Mode. Push button repeatedly to reach programs 1-6. Refer to User Manual or ask your care provider for a list of program options.

Manually set the time using the -/+ buttons.

Manually set the desired pressure.

7 PRESS PLAY/PAUSE

Press the Play/Pause button to begin treatment.



Use the knob to adjust the temperature as needed.

WARNING: Follow the recommendations of your health care practitioner regarding the frequency and duration of use. Improper placement or prolonged use of the GRPro 2.1 could result in tissue damage. Discontinue use immediately if you experience burning, itching, or increased pain and swelling. Monitor the skin receiving cold therapy frequently and discontinue use if changes such as blisters, increased redness, discoloration, or welts occur.

WARNING: It is mandatory to fully read and understand the User Manual before using the device. Failure to follow operating instructions could result in serious injury.

IMPORTANT: Read complete indications, contraindications, cautions, and warnings before using this product.

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RENTAL EXTENSION AGREEMENT

PATIENT INFORMATION: (hereinafter "Patient")

Name:________________________________ Phone: ________________

Address: ____

City:________________________ State: __________ Zip: ____________

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

E-Mail Address: ________________________ Delivery Comments: __________________

EMERGENCY CONTACT:

Name:________________________________ Phone: ________________

☐ Patient declined to provide emergency contact. (check if applicable)

STATEMENT OF CHARGES FOR EXTENSION 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 signing of this Agreement, 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.
TOTAL AMOUNT DUE for EXTENSION	$__________	**PLEASE SUBMIT CHECK PAYMENTS TO:** CoolSystems, Inc. P.O. Box 39000 Dept 34678 San Francisco, CA 94139-0001

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.

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 Game Ready to charge my credit card for the charges specified above.

Card Type (choose one): ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover Last 4 Digits of Card Number: __________

Authorized Personal Representative/ Financially Responsible Party/ Cardholder Name (print): ____________________

Signature: ____________________ Relationship to Patient:_________ Date:______________

Authorized Personal Representative/ Financially Responsible Party/ Cardholder Information (required)

Address: ____

City: ________________________State: ____________Zip:

Phone:________________________ Email: ________________________

CoolSystems, Inc. Representative Signature: ____________________ Date:______________

(AGREEMENT CONTINUED ON BACK PAGE)

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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.

TO BE COMPLETED BY GAME READY REPRESENTATIVE:

ORIGINAL RENTAL INFORMATION:

GAME READY RENTAL UNIT Unit Serial Number:______________________

Original Start Date: ____________ Stop Date: ____________

EXTENSION EQUIPMENT AND ACCESSORIES:

GAME READY RENTAL UNIT Unit Serial Number:______________________

Start Date: ____________ Stop Date: ____________ Number of Weeks: ________

- ☐ Ankle ☐ L ☐ XL
- ☐ Articulated Knee
- ☐ Back
- ☐ C-T Spine
- ☐ Cooling Vest
- ☐ Cryo Cap
- ☐ Elbow
- ☐ Flexed Elbow
- ☐ Half Leg Boot
- ☐ Full Leg Boot ☐ M ☐ L
- ☐ Hand/Wrist
- ☐ Hip/Groin ☐ Left ☐ Right
- ☐ Knee
- ☐ Shoulder ☐ Left ☐ Right | ☐ M ☐ L

TRAUMATIC AMPUTEE

- ☐ Above-the-Knee ☐ Left ☐ Right
- ☐ Below-the-Knee
- ☐ Utility

PAYMENT TYPE: ☐ Private Insurance ☐ Patient Self Pay ☐ Worker's Compensation ☐ No Fault Auto ☐ TriCARE Active Duty Military ☐ Veterans Affairs ☐ Demo

CoolSystems, Inc. Representative Signature: ______________________ Date:______________

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