AXIO BIONICS

NEW PATIENT INTAKE FORM

Return this form to: **submitforms@axiobionics.com**

Patient Information

Patient First Name | Patient Last Name | Patient MI | Date of Birth

Street Address | City | State | Zip Code

Gender: F ☐ M ☐ | Marital Status: S ☐ M ☐ D ☐

Patient Phone 1 | Patient Phone 2 | Patient Email

Emergency/Guardian Contact Information

Contact **1** First Name | Last Name | MI | Phone

Relationship to Patient: Self ☐ Spouse ☐ Patient ☐ Guardian ☐ | Email

Contact **2** First Name | Last Name | MI | Phone

Relationship to Patient: Self ☐ Spouse ☐ Patient ☐ Guardian ☐ | Email

Injury Illness Information

Type of Illness/Injury

Chronic Pain ☐ Spinal Cord Injury ☐ Traumatic Brain Injury ☐ Stroke ☐ Cerbral Palsy ☐ Multiple Sclerosis ☐ ALS ☐

Brachial Plexus Injury ☐ Muscular Dystrophy ☐ Hemispherectomy ☐ Other

Date of Injury or Onset of Illness/Syptoms

Is Injury/Illness the Result of an Accident? (select all that apply)

Work-related ☐ Auto ☐ Other | State Where Accident Occured

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Device Information

What type of AxioBionics Device are you interested in?

- [ ] Wearable Therapy®
- [ ] TripleFlex™
- [ ] WalkAide®/FES
- [ ] Orthotics

Where did you hear about us?

- [ ] Doctor
- [ ] Therapist
- [ ] Orthotists/Prosthetist
- [ ] Website (Web Search)
- [ ] Social Media
- Other ______

Existing Medical Conditions

Condition	Yes	No
Cancer	[ ]	[ ]
In Remission	[ ]	[ ]
Brain Impairments	[ ]	[ ]
Varicose Veins	[ ]	[ ]
Blood Clots	[ ]	[ ]
Heart Condition	[ ]	[ ]
Metal Implants in the body	[ ]	[ ]
Location		
Other Medical Condition	[ ]	[ ]

Condition	Yes	No
Seizure Disorder	[ ]	[ ]
On Anti Seizure Medication	[ ]	[ ]
Seizures Under Control	[ ]	[ ]
Allergies to Adhesives	[ ]	[ ]
Diabetes	[ ]	[ ]
Cardiac Demand Pacemaker	[ ]	[ ]
Manufacturer:		
Phone:		
Model:		

Describe all conditions for which you checked YES, and any others not listed:

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Health Care Providers

List all heath care providers including physicians, specialists, clinicians, physical and occupational therapists, prosthetists and othotists so we may contact them to obtain patient's medical background/history and any other information that will help us process your claim.

Name 1	Name 2	Name 3	Name 4
Specialty	Specialty	Specialty	Specialty
Clinic	Clinic	Clinic	Clinic
Address	Address	Address	Address
Phone	Phone	Phone	Phone
Fax	Fax	Fax	Fax

Primary Insurance Information

Name of Insurance Company

Insurance Phone

Member ID #

Group#

Plan #

Insured's Name (If not the patient)

Insured's Date of Birth

Relationship to Patient

Self ☐ Spouse ☐ Patient ☐ Guardian ☐

Adjuster's Name	Phone	Email	Fax

Nurse/Case Manager's Name	Phone	Email	Fax

Secondary Insurance Information

Name of Insurance Company

Insurance Phone

Member ID #

Group#

Plan #

Insured's Name (If not the patient)

Insured's Date of Birth

Relationship to Patient

Self ☐ Spouse ☐ Patient ☐ Guardian ☐

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Secondary Insurance Information

Adjuster's Name	Phone	Email	Fax

Nurse/Case Manager's Name	Phone	Email	Fax

General Information on Next Steps and Payment Options:

Upon receiving a duly filled copy of this Intake Form, AxioBionics will review the details provided and if required, may contact you for providing additional details. Upon satisfactorily receiving complete details, AxioBionics, if required, may conduct a paid evaluation to determine your candidacy for a particular device or product. After evaluation, you can purchase the product as per the applicable terms.

For Payment of Evaluation and Device/Product, AxioBionics will assist you in choosing the options. We have observed that insurance such as VA Medical Insurance, Auto Insurance, Worker's Compensation, and Tricare are more likely to cover and pay for our products and services, and insurance such as Private Insurance, Medicare, and Medicaid are not likely to cover and pay for our products and services.

We also accept a range of Self-Pay Options, which includes payments through Credit Cards, Bank Transfers and Check.

There are also various external or third party financing options which you can explore. If you are an MS Patient, National MS Society, a nonprofit organization, has paid for our products and services in the past.

The information above has been provided for general understanding of the next steps and payment options. AxioBionics does not represent or warrant the accuracy or completeness of the information, and expressly disclaims all and any liability to any person in respect of anything, and of consequences of anything done, or omitted to be done by
any such person in reliance upon the said information.

General Terms

1 . I understand and acknowledge that the products made by AxioBionics are custom-made or custom-fit and include a significant degree of professional service that render the products nonreturnable. I understand that all sales are final and no refunds will be issued for any reason. Fitting devices such as prosthetics, orthotics, and neuroprosthetics devices to the human body may require making adjustments on an individual basis to ensure proper fit, maximize benefit and function, and ensure safety of use. AxioBionics is committed to this process and, as such, adjustments to fit and performance are included in the AxioBionics one-year warranty

2 . I understand and acknowledge that all sales are final and no product, item or device may be returned to AxioBionics without its prior written authorization. In case of products under warranty, the shipping charges on all authorized returns are my sole obligation

3 . I understand that the purchased product/item/device is solely and exclusively for my own use and not for resale

4 . I understand and acknowledge that AxioBionics is required to provide me with a copy of their Notice of Privacy Practices, which states how they may use and/or disclose my health information. I acknowledge the receipt of Notice of Privacy Practices of AxioBionics. I further acknowledge and understand that this Notice is subject to change, and I can obtain a copy of the revised Notice by contacting AxioBionics, LLC at 734-327-2946.

5 . I understand and acknowledge that I may have a condition which may require orthotic and/or prosthetic treatment by AxioBionics. I understand that my physician has ordered this item/service as part of my treatment and that I am under his/her supervision.

6 . I understand and acknowledge that representatives of AxioBionics have made no guarantees to me regarding the results, outcomes or benefits of any examination, evaluation, product, device, or treatment.

7 . I understand and acknowledge for certain patients that multiple evaluations and visits at the premises of AxioBionics may be required to achieve proper fit and/or desired results

8 . I acknowledge that I have read this entire Form, or it has been read to me, and I understand its contents and agree to its terms.

9 . I have completed this form fully and accurately, and have been given the opportunity to ask questions about this form and the services and products that may be provided.

10 . I am competent and able to make decisions concerning the services and products that may be provided.

11 . I understand and agree that the terms and conditions of this form and the transactions contemplated in it shall be interpreted in accordance with and subject to exclusively the laws of the State of Michigan.

12 . I understand and agree that all disputes with respect to the terms and conditions of this form and the transactions contemplated in it shall be heard exclusively by the courts of Michigan, and I agree to the jurisdiction of such courts. I irrevocably and unconditionally submit to the exclusive jurisdiction of the courts of Michigan for purposes of all legal proceedings arising out of or relating to the terms and conditions of this form or the transactions contemplated in it, and I agree not to commence any legal proceedings except in such courts. I agree to waive any right that I may have to object to an action being brought in the courts in Michigan, or to claim that the action has been brought in an inconvenient forum, or to claim that the courts in Michigan do not have jurisdiction.

Continued on next page

General Terms

13 . I understand and agree that in the event any party institutes legal proceedings to enforce its respective rights, each party shall be responsible for its own attorneys' fees and court costs, including cost of executing, enforcing and/or collecting any judgment at all trial and appellate levels

Authorization

I expressly and unconditionally provide the following authorizations to AxioBionics:

A. General Authorizations:

i . I grant AxioBionics authorization and permission to photograph and record video of my evaluations and sessions to form a comprehensive medical record for the purposes of assembling accurate medical record, assessing my medical condition, referencing my patient data to form a medical opinion and/or recommendation, preparing prescriptions to be sent my to physician, and preparing and/or requesting letters of medical necessity from my physician.

ii . I grant AxioBionics authorization and permission to access my medical history, and communicate with my primary care physician or other medical specialists to obtain the necessary medical information to manage my case.

B. Authorizations when payment mode is self-pay:

i . I grant AxioBionics authorization and permission to recover cost of all items and services provided by AxioBionics from me personally.

ii . In case payment, either in full or part, will be made through Credit Card, I grant AxioBionics authorization and permission to charge my credit card for all the services, items, and devices. AxioBionics, LLC can bill my credit card for the amount indicated in invoices raised, and my total charges will appear on my credit card statement. I will communicate any changes to my credit card information to AxioBionics in a timely manner. I understand that my credit card may be charged for: 1) One-time purchases or trials, 2) Recurring purchases, or 3) Automatic recurring billing for rented or trial equipment.

C. Authorizations when payment mode is either insurance or combination of insurance and self-pay:

i . I grant AxioBionics authorization and permission from this day forward to represent me in the appeals process with my insurance company or any third-party entity or authority for any denial received for AxioBionics products and services.

ii . I grant AxioBionics authorization and permission to access my medical history. This authorization and consent will enable AxioBionics to (a) process medical billing to my insurance company or thirdparty payer (in paper format); (b) communicate with my primary care physician or other medical specialists to obtain the necessary medical information to manage my case; (c) place orders on my behalf for items and products from other vendors and specialists; (d) communicate with my attorney, their attorney, or other legal representative in order to have legal discussions and adjudicate my claim.

iii . I grant AxioBionics authorization and permission to release any medical or other information about me to my other healthcare providers or any other party for the purposes of treatment, payment, or healthcare operations; to my insurance company, health benefit plan, federal health benefits program, third-party payer, third-party administrator, or any other party, including any billing and/or collection service utilized by AxioBionics, necessary to process an insurance claim and/or invoice and collect payment for items/services provided by AxioBionics. I further authorize AxioBionics to contact me via telephone or other mode regarding services to be provided to me.

Continued on next page

Assignment of Insurance Benefits

(Applicable when the payment mode is either insurance or combination of insurance and self-pay

I certify that the information given by me is correct. I request that payment for authorized benefits are made on my behalf, I assign the benefits payable for covered services rendered by AxioBionics and authorize AxioBionics to submit claims to insurance companies, other third-party payers, and administrators for payment. I authorize payment of my benefits directly to AxioBionics.

Payment Policy and Responsibility for Payment

(Applicable when the payment mode is either insurance or combination of insurance and self-pay

I understand that it is my responsibility to know my insurance benefits and coverage for all durable medical equipment, supplies and services provided to me by AxioBionics. I understand that AxioBionics, as a courtesy to me, will make every reasonable effort to bill all of my insurance companies for payment of my account. I understand that my insurance does not pay for everything and may not pay for the services or products (including durable medical equipment supplies) provided by AxioBionics. I understand that any remaining balance is my responsibility. I further agree to be personally and fully responsible for all items and services provided by AxioBionics that my insurance will not pay for and any deductibles and/or co-payments to the fullest extent allowed by law and my health benefits plan. If AxioBionics determines that insurance coverage is not available, I understand I that am responsible for all costs.

Patient's Signature	Print Name	Date

Authorized Representatives's Signature	Print Name	Date

Authorized Representatives's Relationship to Patient:

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NOTICE OF PRIVACY PRACTICES

Return this form to: **submitforms@axiobionics.com**

AxioBionics
6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
Phone 734-327-2946 • FAX 734-800-3203

Authorization

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

Your medical information is personal and AxioBionics is committed to protecting your privacy. We are obligated by law to protect your privacy and give you notice of our privacy practices. This Notice describes how we protect your protected health information and what rights you have regarding your protected health information. "Protected health information" (PHI) means any of your written and oral health information, including demographic data that can be used to identify you. AxioBionics will abide by and act in accordance with the terms of this Notice. Additionally, AxioBionics will notify you if there has been a breach of your unsecured protected health information. If you have any questions, please contact AxioBionics' Privacy Officer at 734-327-2946.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your protected health information that AxioBionics has created or maintained and for any generated in the future. AxioBionics will have copies of our current Notice in our office and this will also be posted on our website, you may request a paper copy of our most current Notice at any time.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the ways in which we may use and disclose your protected healthinformation. AxioBionics may use your protected health information for purposes of providing treatment,obtaining payment for treatment, and conducting health care operations. Your protected healthinformation may be used or disclosed only for these purposes unless AxioBionics has obtained yourauthorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations. Forclarification, we have included some examples. Not every possibility is specifically mentioned. However,all of the ways we are permitted to use and disclose your protected health information will fit within one ofthese general categories.

TREATMENT

AxioBionics may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, referring you to other medical professionals, or obtaining copies of information from other health care providers to facilitate your treatment.

PAYMENT

AxioBionics may use and disclose your protected health information in order to bill and collect paymentfor services. We may disclose your protected health information to a health care plan to determineeligibility or plan responsibilities for benefits, confirm enrollment and coverage, facilitate paymentfor treatment and covered services received, coordinate benefits with other insurance carriers, andadjudicate benefit claims and appeals

HEALTH CARE OPERATIONS

AxioBionics may use or disclose your health information to conduct our business. This may involve disclosures of information for quality assessment and improvement activities, data aggregation services, care coordination, and case management. Other examples include business planning and administrative activities. We will not sell any of your health information unless we have received your express written authorization.

OTHER DISCLOSURES SPECIFIED BY HIPAA WHICH DO NOT REQUIRE YOUR AUTHORIZATION

DISCLOSURES REQUIRED BY LAW

AxioBionics will use and disclose your protected health information when we are required to do so byfederal, state or local law. For example, disclosure may be required by Workers' Compensation statutesand various public health statutes in connection with required reporting of births and deaths, certaindiseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

HEALTH OVERSIGHT ACTIVITIES

AxioBionics may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.

LAWSUITS AND SIMILAR PROCEEDINGS

If you are involved in a lawsuit or similar proceeding, we may use and disclose your protected health information in response to an order of a court or administrative order or in response to a signed authorization.

LAW ENFORCEMENT AND/OR NATIONAL SECURITY

We may disclose your protected health information for law enforcement purposes. For example, in limited circumstances we may disclose your protected health information if you are a victim of a crime. We may provide information about a crime at AxioBionics, or to report a crime that happened elsewhere. Additionally, we may disclose your protected health information for the purpose of identifying or locating a suspect, material witness or missing person. Further, we may disclose your protected health information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

Effective Date of this Notice: February 1, 2025

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DECEASED PATIENTS
AxioBionics may release protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

RESEARCH
Under certain circumstances, we may use and disclose your protected health information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one treatment to those who received another for the same
condition.

SERIOUS THREATS TO HEALTH OR SAFETY
AxioBionics may use and disclose your protected health information to prevent a serious threat to yourhealth and safety or the health and safety of another individual or the public. Under these circumstances,we will only make disclosures to a person or organization able to help prevent the threat.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION BUT WITH OPPORTUNITY TO OBJECT

COMMUNICATION WITH FAMILY
Occasionally, our staff may discuss particular diseases and their inheritance patterns with you or your family members, if you agree.
Other uses and disclosures of your protected health information not covered by this Notice will be made only with your written authorization. If you provide us with such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights with respect to your protected health information:

CONFIDENTIAL COMMUNICATIONS
You have the right to request confidential communications from us. Upon receiving a reasonable written request from you for confidential communications we will communicate your protected health information by an alternative method or to an alternative location."

RIGHT TO OPT OUT
You have a right to opt out of receiving any fund raising notices from AxioBionics.

REQUESTING RESTRICTIONS
You have the right to request a restriction in our use or disclosure of your protected health information for the purposes of treatment (except in emergencies or when required by law), payment or health care operations. We are not required to agree to your request except as described below; if we do agree, we are bound by our agreement except in cases of an emergency or in cases where we are legally requiredor allowed to make a use or disclosure. We are obligated to comply with a request to restrict disclosure toa health plan if the disclosure is for the purposes of carrying out payment or health care operations andis not otherwise required by law and you have paid AxioBionics in full for the services AxioBionics hasprovided. To request a restriction on the disclosure of your protected health information you must makeyour request in writing to the Privacy Officer listed on page one.

INSPECTION AND COPIES
You have a right to request a copy of your protected health information. You must submit your request in writing to the Privacy Officer listed on page one. AxioBionics may charge a reasonable fee for the costs of copying and mailing your information.

AMENDMENT
If you feel that protected health information we have about you is incorrect or incomplete, you maysend us a written request to amend the information. The request must include a reason supporting yourrequest and should be sent to the Privacy Officer listed on page one. We may deny your request if youask us to amend information that is, in our opinion, accurate and complete, not part of the informationkept by us, not part of the protected health information which you would be permitted to see and copy, orif it was not created by us.

LIST OF DISCLOSURES
You have the right to request an accounting of disclosures AxioBionics has made of your protected health information for non-treatment, non-payment or non-operations purposes. Use of your protected health information by AxioBionics for purposes of treatment, payment or operations is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing to the Privacy Officer listed on page one. All requests for disclosures must identify a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional accounting requests may be subject to a reasonable cost based fee.

RIGHT TO NOTICE
You have the right to receive notice and AxioBionics will notify you if there has been a breach of your unsecured protected health information.

RIGHT TO A PAPER COPY OF THIS NOTICE
You are entitled to receive additional copies of this notice of privacy practices at

RIGHT TO FILE A COMPLAINT
If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer for AxioBionics or with the Secretary of the Department of Health and Human Services. To file a complaint with AxioBionics, write to the Privacy Officer listed on page one. AxioBionics will not retaliate against you in any way for submitting a complaint.

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