Patient Consent Form

Your physician has prescribed the inCourage® Airway Clearance Therapy, which is being provided by Respiratory Technologies, Inc. (dba RespirTech). If you have questions regarding this consent form or RespirTech's products, please contact our Customer Care Team at **800-793-1261**.

Release of Medical Information/Health Insurance Portability and Accountability Act (HIPAA)

I authorize RespirTech (including its affiliates, employees, agents and contractors) to request, access, and receive all of my healthcare records from other healthcare providers, insurers, and any other person(s) related to my treatment, obtaining payment for products and services, and healthcare operations (for example, product usage compliance information). I authorize all persons (including RespirTech) with medical or other information about me to release the information to health insurers and healthcare programs related to eligibility, claims, appeals and payments for products or services provided to me by RespirTech. I acknowledge that RespirTech's Notice of Privacy Practices, which is located on the company's website at **www.respirtech.com**, further explains how RespirTech may use and disclose my health information, and my rights and responsibilities under certain privacy laws.

Financial and Patient Responsibilities

I understand my insurance company may choose to either rent or purchase the inCourage Airway Clearance Therapy. I agree to cooperate in the reimbursement process; this may include providing product usage information and assisting in any appeal(s) process. I agree to provide this information to RespirTech promptly. I authorize RespirTech to act as my representative in the appeal(s) process and fully authorize RespirTech to begin the process of appealing any and all denials on my behalf. I also understand that, if for any reason I want to return the therapy and the device is still actively covered under a rental program, I may return the device with no additional financial obligations. I understand I am responsible for any amounts not covered by my insurance provider(s), including but not limited to, any applicable co-payments, co-insurances, and deductibles. In the event the product(s) needs to be returned, I agree to respond to and/or call RespirTech's Customer Care Team at 800-793-1261.

Assignment of Benefits and Insurance Payments

I authorize RespirTech to submit insurance claims and other information necessary to bill my insurance provider(s), on my behalf, for the products and services provided by RespirTech. I authorize payment of medical benefits from my insurance provider(s) directly to RespirTech for the products and services provided to me by RespirTech. I agree to endorse and forward any payments made to me by my insurance provider(s) to RespirTech for products and services billed under this agreement.

Patient Privacy Release and Consent

RespirTech periodically contacts patients and others to inform them of programs, services and initiatives that may be of interest.

If you DO NOT want to be contacted for these purposes, please check here to opt out of such contact ☐.

By signing this consent form, I agree to all of the terms and conditions listed above. I certify that I have read this consent form carefully before signing and fully understand its terms. A copy of this consent form will be provided upon request.

Print Name of Patient or Patient's Authorized Representative	Relationship to Patient
Signature of Patient or Patient's Authorized Representative	Date (MM/DD/YYYY)
Email Address of Patient or Patient's Authorized Representative	

www.respirtech.com (tel) 800.793.1261 (fax) 800.962.1611 2896 Centre Point Drive, St. Paul, MN 55113