

# NEURONETICS

## Physician and Patient Agreement For the NeuroStar Patient Assistance Program

The NeuroStar Patient Assistance Program ("Program") is designed for patients who do not have health insurance and financial resources to pay for a course of treatment of NeuroStar TMS Therapy®. Please complete this agreement and fax to the number listed below. NeuroStar TMS Therapy should not be commenced until the treating physician has been informed by Neuronetics that this application has been approved.

**Patient Instructions:** Please initial each of the boxes that are true.

\_\_\_\_\_ Our/my household gross income is less than \$42,000 per year.

\_\_\_\_\_ I have NO health insurance (private insurance or Medicare)

\_\_\_\_\_ I will not seek reimbursement from any third-party for any treatments provided under the Program.

**Physician Instructions:** Please complete below the name of the patient and place your initials on the line if the statement is true.

Patient Name: \_\_\_\_\_

\_\_\_\_\_ Neither I nor the institution will charge the patient or seek reimbursement from any third party for any costs associated with delivering up to the 26 treatments of NeuroStar TMS Therapy provided for under the Program.

### PHYSICIAN CERTIFICATION

To the best of my knowledge the patient information contained in this form is complete and accurate and I understand the intent and requirements of the NeuroStar TMS Therapy Patients Assistance Program. I understand that Neuronetics or its affiliated companies, agents or subcontractors may require additional information, which I agree to provide it as needed for the purposes of this Program and that Neuronetics, in its sole discretion, may alter or discontinue the Program at any time and without written notice.

Physician's Full Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Contact Number \_\_\_\_\_

### PATIENT CERTIFICATION

I verify that the information contained in this form is complete and accurate to the best of my knowledge and that I understand the intent and requirements of the NeuroStar TMS Therapy Patients Assistance Program. In order for me to be provided this course of NeuroStar TMS Therapy treatment, I understand that Neuronetics, its affiliates and authorized agents administering the Program may contact my physician or other healthcare professionals and that I authorize my physician and other healthcare professionals to release my personal health information as necessary to fulfill the requirements needed in the provision of care in regards to this Program. I understand that if I have intentionally provided false information, Neuronetics may seek legal action to recover any product and/or legal costs and that Neuronetics, in its sole discretion, may alter or discontinue the Program at any time and without written notice.

Patient's Full Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by a representative, please describe representative's authority to act on behalf of the patient. \_\_\_\_\_

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Please fax completed form to Neuronetics at 610-640-4206



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