**Terms and Conditions: iovera° Patient Cash Pay Program**

1. **Eligibility**

The iovera° Patient Cash Pay Program is available for patients who choose to pay cash for all or a portion of the costs of an iovera° treatment.

1. **Treatment Indication**

A licensed healthcare provider may use the iovera° system to apply freezing cold to peripheral nerve tissue to block and/or relieve pain for up to 90 days. The system was not developed, and is not indicated, to treat central nervous system tissue.

1. **Cash Pay Program Restrictions**

I agree that I am a U.S. resident that is 18 years or over with a valid prescription for iovera° treatment.  
  
I am responsible for paying all iovera° treatment costs as those costs are set forth below in paragraph 4 as a cash pay transaction between me and my healthcare provider.

I acknowledge that the cash pay program is not health insurance. Should I wish to seek subsequent reimbursement from my healthcare plan (including government or commercial insurance provider, HSA provider, or FSA provider) after completing my cash pay transaction with my healthcare provider, then I will pursue this with my payment receipt and documentation of the procedure from my healthcare provider. My healthcare provider is not responsible for pursuing subsequent reimbursement on my behalf. I understand that any reimbursement request is subject to the terms and conditions of the specific insurance coverage policy, which may be rejected in full or in part by the insurance provider and that I remain fully responsible for the cash price set forth below in paragraph 4.

1. **Cash Price**

I agree to pay the quoted cash price of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in full to my healthcare provider for the iovera° treatment. This non-refundable payment covers a single use iovera° treatment and does not include costs for any future iovera° treatments, or for related follow-up care.

1. **Disclaimer**

EXCEPT AS MAY OTHERWISE BE EXPRESSLY PROVIDED IN THESE TERMS, ALL SERVICES OR INFORMATION RELATED TO IOVERA° TREATMENT PROVIDED TO YOU BY MY HEALTHCARE PROVIDER, DIRECTLTY OR INDIRECTLTY, INCLUDING, WITHOUT LIMITATION, ALL CONTENT, ARE PROVIDED “AS IS” AND “WHERE IS” AND WITHOUT ANY WARRANTIES OF ANY KIND. THE HEALTHCARE PROVIDER EXPRESSLY DISCLAIMS ALL WARRANTIES, WHETHER EXPRESS, IMPLIED OR STATUTORY, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE AND NON-INFRINGEMENT.

1. **Important Safety Information**

There are inherent risks in all medical procedures, and individual results may vary. Risks associated with iovera° treatment include but are not limited to: bruising, swelling, inflammation and/or redness, local pain and/or tenderness, skin changes and temporarily decreased muscle function near the treatment area. In treatment area(s), patients may experience damage to the skin, skin darkening or lightening, and dimples in the skin, as well as a temporary loss of the ability to use muscles normally outside of the treatment area. Discuss the risks and benefits with your healthcare provider before receiving treatment with iovera°, as there is no guarantee of pain relief effectiveness or duration. Additional treatments may be required if pain returns.

The iovera° system should not be used in people with the following conditions: hypersensitivity to cold or with open and/or infected wounds near the treatment site.

Your healthcare provider is responsible for performing the procedure per iovera° product instructions. For specific questions regarding the procedure and for further information on Indications, Cautions, Warnings, and Contraindications, please contact your healthcare provider.

1. **Records Release**

I authorize my medical records related to the iovera° treatment be released to my physicians and other healthcare providers as needed for treatment purposes.

I have read, understand, and agree to pay cash for the iovera° treatment. I accept the risks and financial responsibilities. This agreement supercedes any contrary statements by staff regarding cash pay terms.

By: [Patient Signature]

Address:

By: [Healthcare Provider Signature]

Address: