Boston Scientific

PATIENT AUTHORIZATION FORM FOR THE INTRACEPT® PROCEDURE

Your physician has determined that the Intracept® System is medically necessary to treat your condition. In order to facilitate your access to this treatment, the manufacturer of the medical technology, Boston Scientific Corporation. ("BSC"), is able to provide certain assistance to you regarding insurance coverage and reimbursement.

In order to provide this assistance, BSC will need to use your Protected Health Information (as defined below). This Authorization will allow your healthcare providers, health plans, and health insurers to disclose this information to BSC and its representatives.

Authorization and Signature

I authorize my physician, physician's practice, any other health care provider, my health plans and health insurers to disclose my Protected Health Information to BSC and its agents and representatives as they request. Protected Health Information includes but is not limited to information relating to my medical condition, treatment, care management, health insurance, and medical record. The information will be used for the following purposes:

- To establish my eligibility for benefits;
- To communicate with me and my healthcare providers, my health plans and my health insurers about my medical care and coverage; and
- To facilitate coverage and reimbursement of my health insurer.

I also authorize BSC and its representatives to contact me directly about these issues.

I understand that information disclosed pursuant to this Authorization is subject to re-disclosure by BSC for the purposes set forth above and will no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations).

I understand that my treatment, payment, enrollment or eligibility for benefits are not conditioned on my signing this Authorization and that I am signing it voluntarily.

I understand that I am entitled to a copy of this Authorization.

I understand that I may revoke this Authorization at any time by mailing my written request to:

Boston Scientific Corporation
Attention: VP Health Economics and Reimbursement
7201 Metro Blvd. Suite 300
Edina, MN 55439

but that any revocation will not apply to any information already used or disclosed pursuant to this Authorization.

I understand that this Authorization automatically expires five (5) years from the date signed below.

I understand that BSC does not guarantee that insurance coverage, reimbursement or any other payment will be made and that I am ultimately responsible for the cost of my care.

I agree that a copy of this form may be treated as a signed original.

Patient or Patient Representative's Signature:_____ Date:_____

Patient's Name: Patient Representative's Name:

Description of Patient Representative's authority to act for the Patient:_____

Employer providing insurance coverage (if applicable):_____

BSC would like to periodically update you regarding the status of your insurance request via email. Your email address will not be used for any other purpose other than Intracept Patient Access Program activities.

Patient Email: _____