AVR Pathway

Phone: 1 (844) 728-4487 | 1 (844) PATH4VR
Fax: 1 (833) 728-4487 | 1 (833) PATH4VR
www.AVRPathway.com

Patient Information

All bold text fields must be completed. Attached demographics sheets are accepted.

Patient First Name _____ Middle Name _____ **Patient Last Name** _____

Patient Date of Birth _____ **Gender at Birth:** ☐ **Female** ☐ **Male**

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ **Type:** ☐ **Cell** ☐ **Home** ☐ **Work**

Email _____ Communication Preference: ☐ Phone ☐ Email

Health Care Proxy Name (If Applicable) _____

Health Care Proxy Number _____ Proxy Relationship _____

Patient Insurance

All bold text fields must be completed. Please attach copies of insurance cards if available.

☐ **Patient Uninsured** ☐ **Workers' Comp** (If WC please provide employer details and claim # in insurance section)

PRIMARY INSURANCE

Primary Medical Insurance _____

Insurance Telephone Number _____

Subscriber ID _____ Group ID _____

Policy Holder Name _____

Policy Holder Date Of Birth _____ Relationship _____

SECONDARY INSURANCE

Primary Medical Insurance _____

Insurance Telephone Number _____

Subscriber ID _____ Group ID _____

Policy Holder Name _____

Policy Holder Date Of Birth _____ Relationship _____

Prescriber Information

All bold text fields must be completed.

Prescriber First Name _____ **Prescriber Last Name** _____

Location Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____ **Fax Number** _____

Prescriber NPI# _____ **DEA#** _____ **Office/Practice Name** _____

Practice Contact _____ **Practice Phone Number** _____

Prescription & Clinical Information

All bold text fields must be completed.

Diagnosis Code: ☐ **M54.5** ☐ **Other** _____

Indication for Use

RelieVRx is a prescription-use immersive virtual reality system intended to provide adjunctive treatment based on cognitive behavioral therapy skills and other evidence-based behavioral methods for patients (age 18 and older) with a diagnosis of chronic lower back-pain (defined as moderate to severe pain lasting longer than three months). The device is intended for in-home use for the reduction of pain and pain interference associated with chronic lower back pain.

Prescribing Information

☐ **RelieVRx** **Instructions For Use: Complete 8 Week Therapy As Directed.** ☐ **Dispense: One VR Device. Dispense As Written.**

☐ Please check this box if the patient does not wish to enroll in AVR Pathway.

Prescriber Authorization

By signing below, I certify that (1) the product prescribed is medically necessary and is in the best interest of the patient listed above; (2) I understand that information I provide on this form, if signed by the patient, will be used by AppliedVR/AVR Pathway and its agents and service partners ("Contractors") as authorized by the patient; (3) I have obtained from my patient his/her consent as required under federal or state laws to release the patient's information on this form to AppliedVR/AVR Pathway and its Contractors, or to the extent the patient listed above has not completed and signed the applicable authorization form, I agree that the terms of the Business Associate Agreement, available at www.AppliedVR.io/baa, will apply to the limited services that AppliedVR will provide. I authorize AppliedVR to forward the above prescription to the applicable dispensing pharmacy/entity.

Prescriber Signature _____ **Date** _____

AVR Pathway

Phone: 1 (844) 728-4487 | 1 (844) PATH4VR
Fax: 1 (833) 728-4487 | 1 (833) PATH4VR
www.AVRPathway.com

Patient Consent and Authorization

Patient First and Last Name: _____ **Date of Birth:** _____

By signing below, I authorize my healthcare provider, durable medical equipment ("DME")/pharmacy provider, and the manufacturer (AppliedVR) to use and disclose my medical information to the AppliedVR Patient Services Department to enroll me in AVR Pathway.

I understand that AVR Pathway will request and my health care provider, health plan, DME/pharmacy, and manufacturer will provide the following information:

Prescriber: clinical notes and other information related to my diagnosis, treatment, and progress of my therapy in support of obtaining coverage to prescribed AppliedVR products.

Health Plan: information regarding my coverage for the prescribed therapy as well as information regarding services related to my diagnosis, treatment, and therapy.

DME/Pharmacy provider: information regarding the prescribed therapy such as prescription, clinical (as applicable from DME providers), demographic information (such as name, address, date of birth, and gender), and contact information (such as email and phone number), identifiers (such as patient ID and device ID), device delivery and tracking information, and notes and other information related to my diagnosis and treatment in support of the dispense of the prescribed therapy.

Manufacturer: information on the device dispensed as well as my utilization of the prescribed therapy and product information related to the device itself. I understand that AVR Pathway may share this information with my prescriber.

I understand that once my information is disclosed, my information may no longer be protected by HIPAA and other federal privacy laws and could be re-disclosed; however, AppliedVR and its agents, and services partners ("Contractors") will only use and disclose my information as described in this form. AVR Pathway is receiving this information to provide program support and administer the AVR Pathway program. This information will be used:

By AVR Pathway and its Contractors to communicate with me (such as by mail, phone, e-mail, and text message) to tailor program-related communications including making communications reminding me to use the AppliedVR product and share information with my healthcare providers about dispensing my device and therapy to me.

By AVR Pathway and its Contractors to determine eligibility and coverage under my active insurance plan, and any applicable out of pocket costs that I may incur when the product is dispensed to me.

By AVR Pathway and its Contractors to de-identify my Information, combine it with information about other patients, and use the resulting information for AppliedVR for research, education, and commercial purposes.

I understand that to administer the program, AVR Pathway uses certain Contractors for providing services to me, which include, but may not be limited to, vendors confirming my coverage and eligibility, dispensing my therapy to me, and providing therapy reminder and other communications to me. I understand that these Contractors have agreed to conform to adhere to applicable law and privacy standards at least as stringent as those contained in this form.

I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or other AppliedVR products. However, if I do not sign this Authorization, I will not be able to receive program support through AVR Pathway. I understand that I may cancel this Authorization at any time by calling 1 (844) 728-4487 or emailing my wish to cancel this authorization to support@avrpathway.com. I understand my cancellation will not apply to any information already used or disclosed by my healthcare providers and staff, health plan, or pharmacy based on this authorization prior to their receipt of the cancellation.

This Authorization expires five (5) years from the date signed below, or as otherwise required by state or local law, unless I cancel it before then. I understand that I am entitled to a signed copy of this Authorization.

I authorize AppliedVR and its Contractors to send necessary text messages to the phone number(s) I provide. I may revoke this authorization and choose not to receive text messages by replying STOP to any such text from AVR Pathway.

By signing below, I confirm I would like to enroll in AVR Pathway, and authorize AppliedVR and its Contractors to provide me with the AVR Pathway support I am eligible for. I understand and agree that if my insurance information changes at any time while I am participating in the Program, I will notify AVR Pathway, as soon as possible, and any such change may affect my eligibility for any such assistance programs I may be participating in.

Patient Signature: _____ **Date:** _____

Health Care Proxy Signature: _____ **Date:** _____

Relationship to Patient: _____

TEXT MESSAGE CONSENT: By signing below, I agree to receive text messages from AppliedVR for the purposes of sharing information related to my diagnosis or treatment (therapy). I provide my signature expressly consenting to recurring contact from AppliedVR or its Contractors at the number I provide regarding products or services via automated or prerecorded telephone call, text message, or email. I understand my telephone company may impose charges on me for these contacts, and I am not required to enter into this agreement as a condition of my treatment, or eligibility for benefits, or other AppliedVR products and services. I understand that I can revoke this consent at any time.

Patient Signature: _____ Date: _____

Health Care Proxy Signature: _____ Date: _____

Relationship to Patient: _____ Mobile number: _____