CRITERION INCORPORATED

CRITERION, INC.
5190 NEIL ROAD, SUITE 430
RENO, NV 89502-8535
(800) 743-0093 V (800) 573-6600 F

*THIS PAGE TO BE FAXED TO **(800) 573-6600**

PATIENT INFORMATION - **PLEASE PRINT**

DATE ISSUED >>	PATIENT LAST NAME >>	FIRST NAME >>	(AC)HOME PHONE >>		(AC)WORK PHONE >>
PATIENT ADDRESS >>		CITY >>	STATE >>	ZIP >>	>> SEX ☐ MALE ☐ FEMALE
EMPLOYER >>	SSN >>		DATE OF INJURY >>	DATE OF BIRTH >>	
PRIMARY INSURANCE COMPANY >>	POLICY HOLDER SSN >>		(AC) PHONE >>		>> INSURANCE TYPE ☐ GROUP HEALTH INSURACE ☐ HMO (PRE AUTHORIZED) ☐ WORKER'S COMP ☐ AUTO INSURANCE ☐ SELF PAY/ OTHER
INSURANCE COMPANY ADDRESS >>		CITY >>	STATE >>	ZIP >>	
POLICY HOLDER NAME >>	POLICY CLAIM NUMBER >>		GROUP NUMBER >>		
SECONDARY INSURANCE COMPANY NAME & ADDRESS (IF APPLICABLE)					(AC) PHONE
SECONDARY INSURANCE POLICY HOLDER NAME		POLICY #			POLICY GRP #
ATTORNEY NAME (IF APPLICABLE)	ATTORNEY ADDRESS	CITY	ST	ZIP	(AC) ATTY PHONE

CLINIC INFORMATION - **PLEASE PRINT**

CLINIC #	CLINIC NAME	CLINICIAN NAME	(AC) CLINIC PHONE	(AC) CLINIC FAX
CLINIC ADDRESS		CITY	STATE	ZIP
DIAGNOSIS		PRESCRIPTION LENGTH - (NO SUBSTITUTIONS)		
		Trial PRN >		
SPECIAL INSTRUCTIONS (IF APPLICABLE) >>		**PRN Supplies as needed >**		
		BODY TYPE / BUILD > SMALL / MEDIUM / LARGE / X-LARGE		
PHYSICIAN'S NAME		PHYSICIAN'S SIGNATURE >>		DATE: >>

PRODUCT INFORMATION

☐ DELIVER TO CLINIC ☐ DELIVER TO HOME DATE NEED:____/____/____ OTHER INSTRUCTIONS: _____

☐ BIOSTIM TENS M7 ☐ BIOSTIM NMS ☐ GV350 ☐ TENS 2000 ☐ GARMENT (SPECIFY TYPE)

☐ QUADSTAR II ☐ BIOSTIM INF ☐ MICROPLUS ☐ EMS 2000 _____

LETTER OF MEDICAL NECESSITY

After examination and evaluation, I have determined that the afore-mentioned patient would benefit greatly from the Criterion unit. This unit will increase circulation, reduce edema, control muscle spasms, reduce pain and expedite healing. This unit is to be used as needed.
I certify that the above prescribed device is medically necessary as part of my treatment program for this patient. The prescribed Device, and any technological advancements, is reasonable and necessary for the treatment of this patient's condition. Because of the exclusive Criterion Electronic Device design and frequency needed to obtain maximum results, ABSOLUTELY NO SUBSTITUTIONS SHOULD BE MADE!

PHYSICIAN'S NAME	ADDRESS			(AC) TELEPHONE	DATE >>
PHYSICIAN'S SIGNATURE >>	CITY	STATE	ZIP	(AC) FAX	

>> REQUIRED INFORMATION

*Group or contracted pricing may apply.

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PATIENT ASSIGNMENT AND POWER OF ATTORNEY

I authorize payment of medical benefits to the Health Care Provider, Criterion, Inc., for any services furnished to me by the health care provider. I authorize the release of hospital or medical information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.
I hereby appoint the Health Care Provider, Criterion, Inc., as my true and lawful attorney, irrevocable, and with full power of substitution, for me and in my name, to ask, demand, sue for, collect, endorse, sign, and receive proceeds from insurance, other health benefits and third party claims relating to services rendered to me by the Health Care Provider.
I agree to coorperate with the Health Care Provider in collecting such amounts. Said cooperation shall include appearing in court if necessary. I authorize my attorney to pay from a favorable settlement all the Health Care Provider claims and that they provide the Health Care Provider with a letter of protection for my claim.

WORKER'S COMPENSATION: RIGHT TO CHOOSE (IF APPLICABLE)

The equipment I received is the equipment ordered by my physician, and was supplied by Criterion, Inc. I choose to use Criterion equipment, it's future upgrades and this particular company. I choose Criterion, Inc. as my provider of my own volition and understand that I have this right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may not change the equipment or interfere with the product or warranty of the company providing these services without my prior knowledge and approval. I choose to have Criterion, Inc. as the provider of any future supplies and accessories.

PATIENT'S AUTHORIZATION

I am under the care of the doctor listed on page 1 of form RSA1V3-1. He/she has determined that a Criterion Medical Device is effective modality for my diagnosed condition. I hereby contract Criterion, Inc. hereinafter referred to as the "Health Care Provider", for said equipment. I understand that the medical devices are subject to technological advancements, and are to be used only for my diagnosed condition, and is issued under the prescription of a licensed physician. I also authorize the Health Care Provider to provide me with supplies for the unit and upgraded product when available. Should my supplies become over or understocked, I bear the responsibility for contacting them and correcting the situation within 30 days. I further understand that the Health Care Provider, Criterion, Inc., functions only as a supplier. I have been fully instructed in the use of said equipment by the doctor and medical staff and I am aware of the warnings and precautions. I absolve Criterion, Inc. of any responsibility as a result of any accident or injuries caused directly or indirectly in the use of the Electromedical Device.
I recognize that in the event my insurance company or attorney refuse to pay the purchase price of the above described items, I will be responsible for the payment and/or return of all items purchased. I will reimburse the Health Care Provider the full retail price of any item lost, stolen or destroyed.

MEDICAL WARNINGS

The long term effects of chronic electrical stimulation are unknown. Safety of Criterion medical devices during pregnancy has not been established. Adequate precautions should be taken in case of persons with suspected heart problems. Do not use Criterion medical devices over the carotid sinus nerves, especially in patients with a known sensitivity to the carotid sinus reflex. Severe spasm of the laryngeal and pharyngeal muscles may occur when the electrodes are positioned over the neck or mouth. The contractions may be strong enough to close the airway or cause difficulty in breathing. Criterion medical devices should not be applied transcerebrally. Criterion medical devices should not be used over swollen, infected or inflamed areas or skin eruptions, e.g., phlebitis, thrombo phlembitis, vericose veins. Caution should be used in the transthoracic application of Criterion Medical Devices in that the introduction of electrical current into the heart may cause arrythmias. Criterion medical devices should be kept out of the reach of children.

LIMITED LIFETIME WARRANTY

The Criterion Medical Device has a limited lifetime warranty to be free from manufacturing defects or workmanship for the original patient prescribed this unit. Should the stimulator fail due to manufacturing defects or workmanship during the warranty period, Criterion, Inc. may, at its option, replace any defective unit with a new or rebuilt stimulator. Criterion's liability shall be limited only to repair or replacement of the stimulator as described. The limited warranty is made only and expressly to the initial purchaser of the stimulator and is not transferable. No warranty is made with the respect to any accessories including pads, lead wires, batteries or any other accessory.

I HAVE READ ALL OF THE INFORMATION ON THIS FORM (RSA1V1B) AND AGREE WITH THE CONTENT

PATIENT'S NAME (PLEASE PRINT CLEARLY):->>	
PATIENT'S SIGNATURE:->>	DATE >>

>> REQUIRED INFORMATION