AMPRION®

Amprion Inc.
10355 Science Center Dr., Suite 240
San Diego, CA 92121

Patient Consent, Assignment of Benefits, and Financial Responsibility Agreement
Not to be used for standard Medicare, Medicaid, or Tricare patients

Patient Name (please print) _____ Patient DOB _____

I understand that my doctor is ordering the Amprion SAAmplify–αSYN (CSF) and/or other tests from a cerebral spinal fluid (CSF) sample obtained from me. This sample will be sent to the Amprion Clinical Laboratory in San Diego CA and the results will be reported to my doctor. SAAmplify–αSYN is a new diagnostic test that aids my doctor in the diagnosis of certain neurodegenerative disorders and can help guide the management of my healthcare. This test was developed and can only be performed by Amprion.

Financial Responsibility

If I do not have insurance or choose not to have Amprion file a claim with my insurance company, I understand that I will be held financially responsible for the service provided.

If I do ask Amprion to submit a claim to my insurance company on my behalf I understand that the test performed may not be covered by my insurance for one or more reasons, including but not limited to: exclusions from my insurance plan, my insurance plan's designation of Amprion as an out-of-network provider, and/or my failure to obtain an authorization or referral for the test. I understand that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

Authorization (please complete):
I authorize payment directly to Amprion Inc. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

_____ _____
Patient or Legal Representative Name (please print) Relationship to patient

_____ _____
Patient or Legal Representative Signature Date

Innovative science. Informative insights. Improved care.

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